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BRINGING UP CHILDREN.¹

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WHEN first asked to give this address I impulsively elected to talk on the bringing up of children, hoping that my work in the field of child guidance would make such a task an easy one, and free from undue anxiety. My first awakening came when I informed my young children of my proposed project, and had to meet a withering blast of scornful disbelief. Even the most superficial investigation on the subject revealed the difficulty of finding such guiding principles as might help in the bringing up of children, and also the doubtful wisdom of doing so. We seem to have a compulsive urge to fit everything into its so-called "proper place", to produce orderliness, to tie off all the ends. The god of efficiency must be appeased at all costs, and so we are trying to find the principles which will ensure that children are brought up "properly", which means that they should rigidly conform to the ideals of what the parents consider correct and pleasing.

So, instead of trying to give advice, I have sought it, and have been led far afield from my original intent. It seemed a good thing to try to find out how children were brought up in earlier and more primitive societies, and what the famous philosophers thought about the subject, and this led more to a study of history, anthropology and philosophy than of psychology.

¹ President's address, delivered at a meeting of the Australasian Association of Psychiatrists in October, 1950, at Melbourne.

The pattern of the paper will be an account of how children have been treated in earlier civilizations, to what extent the societies of men can vary, thoughts from some of the religious and moral philosophers, and finally a few ideas which may have sifted themselves out of this mixed bag of knowledge and myth.

Life in Earlier Civilizations.

In very primitive civilizations, early maturing of the infant is necessary for survival, and Nathan Miller, in his book "The Child in Primitive Society", tells how the Ainu of Japan, a people extremely undeveloped in culture, consider the child who has reached one and a half years of age and is unable to provide for himself as "of no good as an Ainu". He tells us also that the Indian children, after leaving the cradle, are under no sort of confinement, and as soon as they are able to crawl about, are suffered to go stark naked wherever they have a mind, through woods, water, mire and snow; that amongst the New Guinea pygmies "at the age of five or six the boy frees himself from trammels, goes out when he wishes, does what he chooses and merely returns to the family but for his due allowance of sago and fish, or occasionally to refresh himself at the maternal breast"; that if an infant in the Aleutian Isles so much as cried, even in winter, he was carried to the seashore and held naked in the water until he became quiet.

Oscar Christman (1920), in his book "The Historical Child", gives an interesting account of life in the early civilizations, and I quote freely from him. He writes that in Egypt the woman had considerable power and had full control of the home. Children were taught to pay great respect to age, and their greatest duty was respect for

and care of parents. He credits Diodorus with the following statement:

The children of the lower classes were fed very lightly at an incredibly small cost; giving them a little meal of the coarsest and cheapest kind, the pith of the papyrus, baked under the ashes, with the roots and stalks of some marsh weeds, either raw, boiled or roasted, and since most of them are brought up, on account of the mildness of the climate, without shoes, and indeed without any other clothing, the whole expense incurred by the parent does not exceed 20 drachmæ (about thirteen shillings) each, and this frugality is the true reason of the populousness of Egypt.

He goes on to tell that in Japan prior to the advent of Chinese civilization, Japanese women were held in high esteem. Chinese philosophers seem to have had little respect for women, while Buddhism regards women as sinful creatures, a temptation and an snare, an obstacle to peace and holiness. The women loved and tended their children well.

She bears the bairns, but the children carry them. Each preceding child as it grew older, must lug the succeeding baby on its back until able to stand. The rearing of a Japanese poor family is a perpetual game of leap frog.

In Persia the boy remained with his mother till his fifth year, his father never seeing him till then, which was said to have been done to prevent the father from being afflicted by the loss of the child should he die young. Persia proper was a tableland lying between the Caspian Sea and the Persian Gulf, of deep valleys and rapid rivers. Here was produced a vigorous race, the Aryans, a race of our own blood. Little education was given. The child was not supposed to be capable of distinguishing between right and wrong, and so he was taught simply to obey the directions given him. A child was not to be whipped before his seventh year, and was to receive only kind treatment. At the end of the fifth year he left his mother and went to the care of the State; he was given exercises in running, stone-throwing, bow-shooting and javelin-throwing. He was taught to ride and later to hunt. He was trained to endure heat and cold and hunger and fatigue. The boys were taught to speak the truth and learned to be just and pure and courageous and to gain self-control. At fifteen they started military training and were given a strict discipline of military life. At the age of twenty-five years the youth was considered a man and he took his place as a citizen of the State. Girls' education consisted of training in the domestic arts necessary to the care of the home and the bringing up of children. Women held a higher place than in oriental countries. There was no educational system as such. All training was directed to the moral and physical development of the boy. It is said that this training tended to individuality. Caste and its repressive influence did not exist. National feeling was intense. Government was despotic. The ethical aim was high and the individual was encouraged to a high standard of courage, truthfulness and purity. When conquests came, however, bringing wealth and power, degeneration went forward fast and the nation found itself unable to withstand the vigorous peoples who came against it under Alexander.

In Greece, in the heroic age, women were accorded much freedom, but carried a heavy domestic burden along with the care of children. They were well respected and had high standing with the men of that time. In Sparta the State was everything. Both girls and boys received vigorous physical training as a prelude to fighting and child-bearing. In Athens women were not held in so much respect and were closely watched and carefully guarded. Women were considered inferior and thought little better than slaves. Thus the Athenian girl grew up pale, slender and little versed in the ways of the world, whereas the Spartan girl grew up to be a vigorous, robust, healthy woman, ready even to take part in public debate if necessary. In Sparta, if a child survived his cleansing post-birth bath of wine and water, he was subjected to an inspection by a council of State to decide whether he was

fit to live or not. The strong and robust children were permitted to live, but the weak and sickly and deformed children were thrown down a precipice or exposed on the mountains. In Athens, infanticide was entirely in the hands of the fathers, and the infant was placed in a basket or earthenware vessel and left in a temple. This was called "potting the child". Sometimes the children were taken and reared by others. Sometimes they were left to die of exposure. The children in Athens were taught to be quiet and modest and respectful to their elders. The child's religion was expressed in his attitude to his gods and was not connected closely with his moral life, this being determined by the laws of the land and the customs of society. In Sparta the child was left with his mother till aged seven years; then the boys were taken over by the State, and placed in public buildings, eating and sleeping in common, the heir apparent to the throne being the only exception. The life was one of continued discipline and severe hardship. They wore few clothes and their food was very scarce. They learned reverence for their elders, honesty and self-respect, and became good warriors and patriots; but their training did not bring out that individuality which makes for true progress and right living. In Athens the idea of the significance of the individual arose, and although interests centred upon the State, yet the State was considered as being composed of individuals, and the aim of education was to produce all-round men who, by being trained to be individuals, would thus make the best citizens. There was no school education for girls; their place was in the home, and they were wholly educated by the mother and other women of the household.

The Romans possessed intense personality and keen power of organization and control. The Roman woman took an active part in the literary and religious life of the time, and women of the lower classes entered freely into the medical profession, but confined their practice to members of their own sex. In the early days of Rome, the virtue of the women stood out strong, but as ease and luxury came with conquests, licentiousness and not virtue was the dominant trait of the women as well as the men. They practised exposure of the feeble and deformed babies. The power of the father was very great; he could sell his children, disinherit them, select a wife for his son or a husband for his daughter, and he even had the power to put them to death. Love of country and obedience to its law were instilled into the minds of the young, and no other nation ever brought its citizens to such a high pitch of patriotism. Very little formal education was evident until late in Rome's history. Education was in the hands of parents.

In earlier and mediæval Europe civilization fell into a more primitively organized type of culture, and was built round the feudal castle. Children were not brought up in such tight, rigid codes as in the earlier civilizations, and seemed more or less allowed to run wild; but life was tough and hard, and this imposed a natural discipline upon them. The Children's Crusade was a strange but interesting happening and a product of its time and culture.

In A.D. 1212 Palestine had nearly all again fallen into the hands of the Mohammedan. Consequent upon the Church's sending chosen ones to arouse enthusiasm in another crusade, children from every walk of life enrolled in the crusade. Many girls were included, but the greater number were boys under the age of twelve years. The children seemed filled with fervour and nothing could restrain them. When the procession of children went along, it made others wild to join. In France, under Stephen of Cloyes, about 30,000 assembled at Vendôme and went thence to Blois, Lyons and Marseilles. They expected the sea to open up for them to go to Palestine, but it did not. Eventually seven ships were furnished, and about 5000 children went on board to proceed to Palestine. They were next heard of eighteen years later, when it was learnt that two vessels had foundered and all hands had been lost; the other five ships were taken to Buperah and Alexandria and the children sold to the Saracens. Nicholas of Cologne started a similar

crusade in Germany, and eventually set out with 20,000 young persons, mostly boys, aged under twelve years; of these about 7000 arrived at Genoa, but here again an unfriendly sea barred their progress, and the expedition disintegrated somewhat. A few, however, reached Pisa, from where two shiploads of children set sail for the Holy Land, but nothing further is known of them.

Stoddard (1929), in his book "The Story of Youth", states that when Elizabeth died in 1603, an era ended which was a happy one for children. The seventeenth century was one of strife, culminating in religious fanaticism and civil war. England was split between Cavaliers and Puritans, who tended to go to opposite extremes in their family lives. Puritan children were warped and terrified by sour discipline and a "hell-fire" theology; while roistering, mocking Cavaliers set their offspring such bad examples that they grew up wild, hard-drinking young blades, or vain, fashionable beauties, with little in their heads but gossip and the latest styles. In many Puritan households parents crushed their children beneath the yoke of a fanatical discipline. "Your child is never too little to go to hell." Children were ordered thus: "Play not on the Lord's Day, for the Devil will be thy play-fellow." "Play not at cards, for they are the Devil's Books." "They that go to bed without praying have the Devil for their bedfellow." The eighteenth century was for most children a joyless period. Perhaps in no other age were they more repressed by their elders, who trimmed and primed their young minds as methodically as they did the trees and hedges of their stiffly formal gardens. Children were held at arm's length, and family life was marked by a formality which to us is almost inconceivable. Child labour was a growing evil: "The creatures (that is, the children) were set to work as soon as they could crawl, and their parents were the hardest taskmasters." In the spinning and weaving mills, multitudes of boys and girls of eight and nine years and even as young as six, were toiling under most dreadful working conditions, for pitiful wages, twelve, fifteen and even seventeen hours a day. Child labour agents developed a sort of juvenile slave-trade, and they would be sent off in wagon loads from London to the mills in Yorkshire and lost for ever to their parents, who had received a small sum of money for them.

Over the past one hundred and fifty years the attitude to the child has gradually improved, and we have entered a period of child worship. The pendulum even seems to have swung a little too far.

Primitive Societies.

The second part of this paper deals with the tradition of some primitive societies and shows up the great differences which can arise in people subjected to different cultural drives. Ruth Benedict (1935), in her book "Patterns of Culture", states that the life history of the individual is first and foremost an accommodation to the patterns and standards traditionally handed down in his community.

From the moment of his birth the customs into which he is born shape his experience and behaviour. By the time he can talk, he is the little creature of his culture, and by the time he is grown and able to take part in its activities, its habits are his habits, its beliefs his beliefs, its impossibilities his impossibilities. Not one item of Man's tribal social organisation, of his language, of his local religion, is carried in his germ plasm. Culture is not a biologically transmitted complex. What really binds men together is their culture, the ideas and standards they have in common.

The first race she deals with are the Pueblos of New Mexico. They live in the midst of America, under the old native custom. Theirs is the only Indian culture which has maintained its cultural form despite contact with "civilized" influences. She describes them as follows:

The Zuni (as they are called) are a ceremonial people, a people who value sobriety and inoffensiveness above all other virtues. The ceremonial life not only demands their time; it preoccupies their attention. Probably most grown men among the Western Pueblos

give to it the greater part of their waking life. According to all the tenets of their religion, it is a major matter if one of the eagle feathers of a ceremonial mask has been taken from the shoulder of the bird instead of from the breast. Every detail has magic efficacy.

She points out the basic contrast between the Pueblos and other Indian cultures of North America as

the contrast that is named and described by Nietzsche in his studies of Greek tragedy. He discusses two diametrically opposed ways of arriving at the values of existence. The Dionysian pursues them through the annihilation of the ordinary bounds and limits of existence; he seeks to attain in his most valued moments escape from the boundaries imposed upon him by his fine senses, to break through into another order of experience. The desire of the Dionysian, in personal experience or in ritual, is to press through it toward a certain psychological state, to achieve excess. The closest analogy to the emotions he seeks is drunkenness, and he values the illuminations of frenzy. With Blake, he believes, "the path of excess leads to the palace of wisdom". The Apollonian distrusts all this, and has often little idea of the nature of such experiences. He finds means to outlaw them from his conscious life. He keeps to the middle of the road, stays within the known map, does not meddle with disruptive psychological states.

In Nietzsche's fine phrase, even in the exaltation of the dance, he "remains what he is, and retains his civic name". The Southwest Pueblos are Apollonian. The known map, the middle of the road, to an Apollonian is embodied in the common tradition of his people. They do not seek ecstasy by fasting, by torture, by drugs or alcohol, nor do they seek it in the dance. Their love of moderation to which their civilization is committed has no place for them. They have developed a distrust and a repulsion for any experience which takes the individual in any way off the beaten track or forfeits his sobriety. The greatest sin is individuality and any show of personal authority is severely frowned upon. "A man with natural authority of manner is a liability and he may be accused of witchcraft and hung by his thumbs till he confesses." All individuality is submerged into group activity, as all strong emotions as grief, anger and jealousy take second place to moderation and sobriety.

It is a matriarchal society; the house, land and corn belong to the women of the household, and the husbands are outsiders. Marriage is a casual affair, as is divorce, and the husband may, for some quite trivial cause, return to his mother's household for good. The children are brought up by the family group rather than by the parents and seem little disciplined by anyone. Indeed, any show of personal authority here would be severely discouraged. The child grows up "without either resentment or the compensatory day dreams of ambition". As regards sex and sin, the Zuni have no sense of sin. Sin is unfamiliar to them, not only in sex, but in any experience. They do not suffer from guilt complexes, and they do not consider sex as a series of temptations to be resisted with painful efforts of the will. Chastity as a way of life is regarded with great disfavour. "Pleasant relations between the sexes are merely one aspect of pleasant relations with human beings." Their attitude of toleration and moderation in all things is reflected in their philosophical outlook. They do not picture the universe, as we do, as a conflict of good and evil. They are not dualistic. They do not see the seasons, nor man's life, as a race run by life and death (or good and evil). Life is always present, death is always present. Death is no denial of life. The reasons unroll themselves before us, and man's life also. Their attitude involves "no resignation, no insubordination of desire to a stronger force, but the sense of man's oneness with the universe. The breath of the Gods is their breath, and by their common sharing all things are accomplished. They have made a civilisation all of whose delight is in formality and whose way of life is the way of measure and of sobriety".

The second race Ruth Benedict describes is the Dobu. Dobu Island lies in the D'Entrecasteaux group off the

southern shore of eastern New Guinea. She writes of the Dobu:

They are lawless and treacherous. Every man's hand is against every other man. All existence is cut-throat competition, and every advantage is gained at the expense of a defeated rival. This competition is always secret and treacherous. The good man, the successful man, is he who has cheated another of his place. Ownership is jealous, suspicious and fiercely exclusive. Dobuan conventions exclude laughter and make dourness a virtue. Theft and adultery are the object of the valued charms of the valued men of the community. These characteristics have arisen because the social forms which obtain in Dobu put a premium upon ill-will and treachery and make of them recognised virtues of their society. Life in Dobu fosters extreme forms of animosity and malignancy which most societies have minimised by their institutions. Dobuan institutions on the other hand exalt them to the highest degree. All existence appears to him as a cut-throat struggle in which deadly antagonists are pitted against one another in a contest for each one of the goods of life. Suspicion and cruelty are his trusted weapons in the strife and he gives no mercy, as he asks none.

Margaret Mead (1939), in her book "From the South Seas", tells of five primitive cultures. The first is that of Samoa, which is characterized by freedom in sex, lack of economic responsibility, and lack of any pressures to make choices, and which emphasizes a graceful, easy, diffuse emotional life and a relaxed dependence upon reliable social forms and no conception of original sin. In Samoa the person with pronounced individuality and a capacity for strong feeling, a bent for religious or artistic expression, a fondness for speculative thought, is at a disadvantage. One curious custom is that few children live continuously in one household; the minute that the mildest annoyance grows up at home, the possibility of moving to a relative's house moderates the discipline and alleviates the child's sense of responsibility.

The second society, that of Manus, was not unlike the more puritan forms of our own.

The adults were driven by a harsh, competitive system, hard working and little tolerance for pleasure or art; each man working for himself and for his own household; the future economic security of one's children was a principal goal. They, also, like our Puritan Fathers, predicate original sin, that is, they assumed that man's fundamental drives were immoral, and that man must be broken to fit the accepted form regarded as good life. Therefore, the prescribed educational efforts of society are directed towards thwarting intractable immoral tendencies, assumed to be present in all human beings. But the Manus children had no part in this adult world of money values and hard work; they were left free to play all day in a pleasant co-operative world where there was no property and no possessiveness. And yet, when they passed adolescence, the generous, gay, co-operative Manus children turned into grasping, competitive, sullen, tightlipped Manus adults. The Manus emphasise the practical virtues of abstinence, thrift, industry, denial of the flesh, postponement of all satisfactions, and individualistic pursuit of personal gain. The artist, the philosopher, individuals valuing personal relations, find no place in this society.

The third society told of by Margaret Mead was that of the Arapesh of New Guinea:

... who assume that all human beings, male and female, are naturally unaggressive, self-denying, lightly sexed, comfortably domestic, concerned with growing food to feed growing children. They do not conceive the personality as developed by frustration. All value is placed on peaceful, non-aggressive parental activity and those who feel intensely or violently are disallowed.

The fourth society, that of the Mundugumor, assumes that all children, male and female, are naturally aggressive and hostile.

To such people Mundugumor society, with its sex foreplay which is more like a battle royal, its premium on headhunting, its violent, swaggering quarrelsome social pattern, where every man's hand is turned against his brother is congenial.

The fifth society, the Tchambuli, "attempt to standardize the personality of the sexes in contrasting ways; they expect men to be responsive, dependent, compliant, interested in the arts, women to be bold, competent, initiating and economically more responsible".

The Views of Philosophers.

We now turn from facts to fancy, or rather to what some of the philosophers thought of the bringing up of children.

Plato (429 to 347 B.C.) put forward an ideal that in the balanced philosophical life is to be found the solution of all human problems, and he sets himself to release the sources of that life. The ideal is an adult ideal which was the Hellenistic ideal. The child is not entitled to a child's life—from the beginning he is trained in the civic virtues of self-control, manliness and the like. There is no question of education for education's sake, but simply for the sake of adult civic life. Plato insists on starting with a clean sheet, presupposing only the general aim of Hellenic culture—that is, of converting chaos into cosmos and of directing instinct by reason. The ideal citizen is the exact antithesis of the private spirit, which looks to private gain such as wealth, pleasures and power. Every childish potentiality must be encouraged to pattern itself upon the model of the ideal community. Preparation is made for adult life in the ideal community. The expressive cries of infancy are taught to shape themselves into music and language, the playful curiosities lead to science and philosophy. Childish games become gymnastics and military exercises. He says: "Of all animals the boy is the most unmanageable—he is the most insidious, sharp witted and insubordinate of all animals".

From Montaigne (1553 to 1592) we learn to do by doing.

A child should not be dangled and brought up in his mother's lap. It is not enough to fortify his soul; you must also make his muscles strong; accustom him to heat and cold, to wind and sun, and to dangers he ought to despise. . . . Never take upon yourselves, much less leave to your wives, the bringing up of children; leave their shaping to fortune, under natural and human laws.

Seneca tells us: "A man of good natural parts needs little learning"; and again: "There is a vast difference in forbearing to sin and not knowing sin"; and he says of Alcibiades: "He could outdo the Persians in pomp and luxury, the Lacedaemonians in austerity and frugality, and could be as temperate in Sparta and as voluptuous in Ionia".

From Rousseau (1712 to 1778) we learn:

Everything is good as it comes from the hands of the Author of nature, but everything degenerates in the hands of man. To live is the trade I teach. He who knows how best to support the good and the evil of this life, is, in my opinion, the best educated. We ought to teach him—to bear the blows of destiny; to brave opulence and misery; to live, if need be, amid the snows of Iceland or on the burning rocks of Malta. It is in vain that you take precaution against his dying, for after all he must die. It is of less consequence to prevent him from dying than to teach him how to live. To live is not to breathe, but to act—it is to make use of our organs, of our senses, of our faculties, of every element of our nature, which makes us sensible of our existence. The man who has lived most is he who has the keenest sense of life. All our wisdom consists in servile prejudices, all our customs but servitude, worry and constraint. . . . Civilised man is born, lives and dies in a state of slavery. At birth he is stitched in "swaddling clothes"; at his death he is nailed in his coffin; and as long as he preserves the human form he is fettered by our institutions. . . . Their first language is a tear, the first gifts they receive from you are chains. The child should love his mother before he knows that this is his duty. Harden their bodies to the changes of seasons, climates and elements as well as to hunger, thirst and fatigue; dip them in the waters of the Styx (as Thetis plunged her son).

Temperance and labour are the two real physicians of man; labour sharpens his appetite, and temperance prevents him from abusing it. Cities are the graves

of the human species. After a few generations, races perish or degenerate; they must be renewed, and this regeneration is always supplied by the country. Send your children away, therefore, so that they may renew themselves, so to speak, and regain amid the fields the vigour they have lost in the unwholesome air of places too thickly peopled. The education of man begins at birth. The only habit which the child should be allowed to form is to contract no habit whatever. Let him not be carried on one arm more than on another, nor to desire to eat, to sleep, or to be awake at the same hours, nor to be unable to stay alone by day or by night. All wickedness comes from weakness. A child is bad only because he is weak; make him strong and he will be good. He who can do everything does nothing bad. Try to limit their desires to their powers. . . . We accustom children to the habit of luxury from birth. . . . As long as he is crying I do not go to him, but I run to him the moment he has become still. If he falls and bumps his head; if his nose bleeds, or if he cuts his head, instead of rushing to him with an air of alarm I remain unmoved, at least for a little time. The mischief is done, and he must necessarily endure it; in reality it is not so much the cut but the fear which torments him when he is wounded. If he sees that I remain cool, he will soon regain his own composure. It is at this age that the first lessons of courage are learned, and that, suffering slight pains without dismay, we learn to endure those that are greater. Children left alone seldom harm themselves. The blessings of liberty are worth many wounds. That barbarous education which sacrifices the present to an uncertain future, which loads a child with chains of every sort—the age of mirth is passed in the midst of tears, chastisements, threats and slavery. The victim is tormented for his own good. The first education, then, ought to be purely negative. It consists not at all in teaching virtue or truth, but in shielding the heart from vice, the mind from error. Exercise his body, his organs, his senses and his powers, but keep his soul lying fallow as long as you possibly can. Rattle-headed children become commonplace men.

So much for Rousseau.

Plutarch says, "Choose the best way of living and nature will make it pleasant for you".

Froebel (1782 to 1852), the creator of kindergarten, had Rousseau's confidence in the principles of the child nature.

Let childhood ripen in children and begin education by proper exercise of the muscles and the senses given at the right time and always in harmony with the nature of the child and within its easy capacity. The child must be sustained by its own "self activity", by its own powers and momentum. We were in such a hurry to force children out of childhood into manhood or womanhood that we ran a risk of hurrying them into their graves.

John Locke, born in 1632, sees education as a preparation for life; he fails to see it as part of life itself. Discipline should begin early. "A sound mind in a sound body is a short but full description of a happy state in this world." "I imagine the minds of children as easily turned this way or that, as water itself." "Our bodies will endure anything that from the beginning they are accustomed to", and this applies probably to our minds too. He stressed the necessity of self-denial and self-mastery, but believed that learning should be motivated by being made attractive and pleasurable. The same thought comes from Persius: "The clay is moist and soft; now make haste, and form the vessel, the wheel turns fast."

The Christian ideal can be put from several different angles. Sadoletto, born in 1477 (Campagnac and Forbes, 1916), wrote as follows:

This fear and love of God should be our chief endeavour with a child—that this root, so fruitful in blessedness, be most firmly fixed in his heart as early as may be, while the ground is, so to say, untenanted and the mind, thanks to its newness in nature and origin, is not yet seized by alien and even conflicting ideas.

He says a father should himself afford a pattern to be copied of a well-balanced nature, his one vehement passion the pursuit of goodness and honour.

This art of moderation, which as I said is the supreme ornament of life, decorating it and illuminating it in every part, this knowledge of what is fit in every circumstance, on every occasion, under every condition is the gift, the work of philosophy. . . . Dignity of course must always be kept; a father should never let himself sink to the level of familiarity, or become the boon companion of his son. On the other hand he should be no formal or rigid moralist, afraid of giving his son ample proof of courteous and warm-hearted consideration. But he must control his affection lest the child be spoiled by excessive indulgence, cast away all respect and reverence for his father.

John Wesley (1703-1791), the founder of Methodism, takes a much more repressive attitude with children:

The will of a parent is to a little child in the place of the will of God. Therefore studiously teach them to submit to this while they are children, that they may be ready to submit to His will when they are men. A wise parent should begin to break their child's will the first moment it appears, and after you have once begun you must never more give way. It is hard to say whether self-will or pride be the more fatal distemper. It was chiefly pride that threw down so many of the stars of Heaven and turned angels into devils. Almost all parents are guilty of feeding the flame of vanity by praising their children to their face. If you are sensible of the folly and cruelty of this, see that you sacredly abstain from it and do not suffer others to do it. Teach your children, as you possibly can, that they are fallen spirits. Show them that, in pride, passion and revenge, they are now like the devil; and that in foolish desires and grovelling appetites, they are like the beasts of the field.

A wise and kind parent will be equally cautious of feeding "the desire of the eyes" in her children. She will give them no pretty playthings, no glittering toys, shining buckles or buttons, fine or gay clothes.

He is particularly hard on grandmothers:

Let her on no account have the least share in the management of your children. She would undo all that you have done; she would give them their own will in all things. She would humour them to the destruction of their souls; if not their bodies too. In four-score years I have not met with one woman that knew how to manage grandchildren. Whatever pains it costs conquer the child's stubbornness. Let a child, from a year old, be taught to fear the rod and to cry softly. In order to do this let him have nothing he cries for, absolutely nothing, great or small; else you undo your own work. Make him do as he is bid, if you whip him ten times running to effect it. Let none persuade you it is cruelty to do this; it is cruelty not to do it. Break his will now, and his soul will live, and he will probably bless you to all eternity.

This stern attitude of Wesley's does not seem in tune with Christ's words: "Suffer the little children to come unto me, and forbid them not; for of such is the kingdom of God."

Conclusion.

From these few facts of ancient history, a quick peep at some primitive cultures and a few philosophical titbits, can any lesson be learned?

The five contrasting societies so widely separated in ideals and ways of living have shown the extreme malleability of human nature. In them it is seen that any natural human trait can be trained into a grotesque shape or cut back and withered to nothingness. It is the cultural drives of the particular adult civilization that determine how the child's nature will eventually be bent. These cultural drives are created out of time by the circumstances of natural geographic factors, such as the type and position of land, climate, rainfall and fertility of the soil, by the influence of outstanding individuals who, after all, constitute society, and by the various enemies that may continually threaten such a civilization, and many other factors about which we know very little. In any case, patterns of culture are created which determine the upbringing of the child. Tradition becomes the unseen obsessive tyrant who produces conformity to the social pattern. Deviation brings ridicule and social suicide. The fear of being different is one of our most dominating motives.

The greatest tragedies of children at school are not those that we would expect, but in not wearing the right length of shirt or the right sort of dress, or of not being able to join a particular dancing class.

Of those who cannot conform to traditional standards Ruth Benedict makes the following statement:

The maladjusted and abnormal ones are those whose congenital responses have not been supported by the particular institutions of his culture. Amongst the Dobu the individual who is disoriented is the man who was naturally friendly and found activity an end in itself. He was a pleasant fellow who did not seek to overthrow his fellows or to punish them. The person unsupported by the standards of his time and place and left naked to the winds of ridicule has been unforgettably drawn in European literature in the figure of Don Quixote. This orthodox upholder of the romantic chivalry of another generation became a simpleton.

However, man and his society are interdependent, and man is, after all, the final essential of social life. We have seen the State all-powerful and the child trained for the sole purpose of citizenship, as in early Greece and Rome, and now later in Fascist and Communist countries. Here all energies are drained away from personal aims to those of the State, and life is reduced to a simple monotony. This, we feel, is too great a price to pay for security, and we believe that the State should provide only a menu from which its members can obtain a rich and satisfying fare.

Probably somewhere between these extreme cultures and conflicting patterns of living, between the pleasant "sinless" beachcombing existence of the Samoan and the uninviting, rigid, puritanical fanaticism of Wesley, or the harsh, uninteresting discipline of Sparta and now of the Fascist-Communist State lies a more fruitful, interesting and enduring way of life. We should try to preserve those patterns of culture which have proved good and satisfying and resist those that we know are evil.

You have received little practical advice on the bringing up of children, but you can see that I was side-tracked into presenting only one aspect of it—namely, the effect of tradition on the growing child.

This proved an interesting and all-important influence, and the lesson learned surely is that, after we have brought a child successfully through the tender years—and this aspect was not dealt with—we can more or less hand the child over to society to complete his bringing up. We should let the child fall naturally into the social grooves of his age group, dress him like his fellows, do nothing which will make him stand out and appear different from them. Good parents, cease worrying about the bringing up of your children or how they will turn out; tradition can do it all for you and do it better. Save your energies for more productive avenues of expression, live more fully yourself, and perhaps your example may be followed by your child. Change tradition if you like, but do not try to change your child. Have faith in the goodness of our own society and let your child float calmly on its tide; he will be carried along eventually to a safe and secure haven.

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RETROPUBLIC PROSTATECTOMY: A COMPARISON BETWEEN ITS RESULTS AND THOSE OF PREVIOUS METHODS OVER A THREE-YEAR PERIOD.

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PROSTATECTOMY by the retropubic approach of Millin was first performed in this hospital in January, 1947. Since that time the great majority of operations for prostatectomy have been performed through the retropubic approach. It seemed of interest to compare our results by this method with those in the preceding three years. During this period, perineal, suprapubic and occasionally transurethral prostatectomy were the methods of choice.

For this review the three-year period 1947 to 1949 inclusive has been studied and compared with the period 1944 to 1946 inclusive. During both periods the operations were performed by the general surgeons attached to the staff of this hospital. At least six surgeons have contributed to the total figures presented in each series. Since the retropubic method of prostatectomy has been performed there has been a considerable reduction in the mortality rate for this operation, as will be seen in Tables IA and IB.

TABLE IA.
 Three-Year Period 1947 to 1949.

Type of Operation.	Number of Cases.	Cured.	Relieved.	Died.	Mortality Rate.
Retropubic ..	103	84	11	8	8%
Freyer ..	1	1	—	—	—
Perineal ..	1	1	—	—	—
Transurethral resection ..	1	1	—	—	—
Total ..	106	—	—	8	—

The overall mortality rate was 7.5%. The condition was simple hypertrophy in 100 cases and malignant disease in six.

In descriptions of the post-operative course of the retropubic operation it would appear that in the great majority of cases the catheter can be removed between the third and sixth days after operation, and the patient is usually

TABLE IB.
 Three-Year Period 1944 to 1946.

Type of Operation.	Number of Cases.	Cured.	Relieved.	Died.
Perineal ..	17	7	2	8
Suprapubic ..	55	39	3	13
Transurethral resection ..	8	0	7	1
Total ..	80	—	—	22

The overall mortality rate was 27.5%. The condition was simple hypertrophy in 73 cases and malignant disease in seven.

fit for discharge from hospital about fourteen days after operation. The impression was that the period in hospital after operation in this hospital differed considerably from that of the average case as described. It was therefore thought that it would be interesting to observe the average period in hospital for patients on whom this operation had been performed and also the longest post-operative period during which any individual patient has had to remain in hospital. These figures are compared with those of the

preceding three-year period before the retropubic operation (Tables IIA and IIB).

TABLE IIA.

Three-Year Period 1947-1949: Average Number of Days in Hospital.

Type of Operation.	Total. ¹	After Operation. ¹
Retropubic:		
All cases	38 (162)	28 (67)
Deaths excluded .. .	39	31
Freyer	35	34
Perineal	30	21
Transurethral resection .. .	34	22

¹ The figures in parentheses are those of the patient with the longest period in hospital.

In the three-year period 1944 to 1946 the total number of prostatectomies performed was 80; the total number of deaths amounted to 22, the overall mortality rate being 27.5%, as shown in Table IB.

As will be seen in Table IB, perineal prostatectomy was performed 17 times with eight deaths, suprapubic prostatectomy 55 times with 13 deaths, and transurethral resection eight times with one death. In this series there were 73 cases of simple hypertrophy of the prostate and seven cases of carcinoma.

TABLE IIB.

Three-Year Period 1944-1946: Average Number of Days in Hospital.

Type of Operation.	Total. ¹	After Operation. ¹
Perineal:		
All cases	48 (133)	38 (123)
Deaths excluded .. .	56	39
Suprapubic:		
All cases	55 (150)	34 (135)
Deaths excluded .. .	62	42
Transurethral resection:		
All cases	53	33
Deaths excluded .. .	58	34

¹ The figures in parentheses are those of the patient with the longest period in hospital.

After the perineal operation the average number of days in hospital was 38 for all cases, and 39 days when deaths were excluded. After suprapubic prostatectomy the average number of days in hospital for all cases was 34, and 42 days when deaths were excluded; after transurethral resection the figures were 33 days' average stay for all cases and 34 days when deaths were excluded.

In the second three-year period, 1947 to 1949, the total number of cases was 106, the deaths were eight, two after readmission to hospital being excluded, and the overall mortality rate was 7.5%. In this period 103 patients had the retropubic operation performed, one the suprapubic procedure by Freyer's method, one a perineal procedure, and one transurethral resection. From 103 retropubic operations there were eight deaths, a mortality rate of almost 8%. There were no deaths in any of the three cases in which the other methods of operation were used. In this series 100 patients had simple hypertrophy of the prostate and six had carcinoma.

The average number of days in hospital after the retropubic operation was 28, and deaths excluded, 31 days—a slight reduction in the period in hospital compared with the perineal and suprapubic operations. As these operations in both series had been performed for the main part by the same surgeons, it would appear that the retropubic operations, as far as the mortality rate is concerned, is a safer operation than either the perineal or the suprapubic operation.

However, other factors play an important part in the reduction in mortality rate in the second series. Since 1947, when a blood bank was established in this hospital, it has become a routine procedure for every patient undergoing a retropubic prostatectomy to have a blood transfusion commenced in the operating theatre. Before this time blood transfusion for prostatectomy was seldom, if

ever, given during operation, and the quantity of blood given during any post-operative transfusion rarely exceeded one pint. If similar blood bank facilities had been available for the first series of operations, it is probable that the mortality rate would have been considerably lower.

In the former series, also, sulphadiazine was the drug of choice for the control of infection. In the later series a sulphonamide drug was almost invariably combined with penicillin for this purpose. It is possible that penicillin contributed to some extent to the decreased mortality rate in this series by the control of post-operative respiratory infections, although it is unlikely that it had much effect on the control of post-operative renal or bladder infections. In those cases in which chronic cystitis developed after operation, the organisms were most commonly *Proteus vulgaris* and *Staphylococcus albus*, sometimes combined with *Bacillus coli communis*. These organisms are not penicillin-sensitive.

The contention that the mortality rate in the first series would have been reduced considerably had blood bank facilities been available is borne out by a study of the analysis of deaths in this series, as shown in Table III.

TABLE III.
Analysis of Deaths, 1944 to 1946.

Type of Procedure.	Days After Operation.	Number of Deaths. ¹	Cause.
Perineal.	1	1	Post-operative hæmorrhage.
	2	1	Post-operative shock.
	3	1	Shock; extravasation of urine.
	18	1	Uræmia.
	21	1	Coronary occlusion.
	22	1	Cerebral arterial degeneration.
	32	1	Pulmonary embolus.
	Total	7	
Suprapubic.	0	3	Post-operative shock.
	1	3	Post-operative shock.
	2	1	Post-operative shock.
	3	1	Renal failure.
	4	2	1, acute pyelonephritis and uræmia; 1, possible cerebral hæmorrhage.
	10	1	Uræmia.
	24	1	Uræmia.
	42	1	Pyelonephritis and uræmia; gangrene of suprapubic wounds.
	Total	13	
Transurethral resection.	—	1	Patient died after readmission to hospital with metastases.

¹ One death excluded—patient died after readmission to hospital with metastases.

Of the seven patients who died after the perineal operation, two died of post-operative hæmorrhage or shock, or both, in the first two days after operation. Of the 13 patients who died after suprapubic prostatectomy, seven died of post-operative shock during the first two days after operation. It is reasonable to assume that had these patients been given the benefit of blood transfusions the operative mortality rate would have been less.

The cause of death and the day after operation on which death occurred in the second series are also shown in Table IV. It is of interest to note that two of these eight deaths were due to post-operative shock, one on the first day and one on the second day after operation.

A striking feature of the series of retropubic operations was the high incidence of complications which developed. The nature of the complications which were encountered can be seen in Table V.

It will be noted that post-operative stricture has occurred 10 times and post-operative chronic cystitis 16 times. All the patients with post-operative stricture developed or had chronic cystitis, and these patients are included in the total of 16 with cystitis. The majority of patients with post-operative stricture have been readmitted to hospital,

and some on more than one occasion, for the passage of sounds and further treatment by bladder irrigations for the chronic bladder inflammation.

TABLE IV.
Retropubic Prostatectomy.

Days after Operation.	Number of Deaths. ¹	Cause.
1	4	1, shock. 1, pyonephrosis and toxemia. 1, possible cerebral thrombosis. 1, cardiac failure.
2	2	1, post-operative shock. 1, extraperitoneal extravasation.
3 12	1 1	Renal failure (82), shock. Congestive cardiac failure.
Total ..	8	

¹ Two deaths are excluded; the patients died after readmission to hospital one from agranulocytosis, one from pyelonephritis.

The bladder infection has almost invariably been of the alkaline-incrustation type. This is brought about by the presence of urea-splitting organisms, most frequently *Staphylococcus albus* and *Proteus vulgaris*, which in alkaline urine break down urea with the formation of ammonia; this combines with calcium phosphate and magnesium phosphate, leading to the formation of triple phosphate, which is insoluble in alkaline urine. The insoluble phosphate has frequently become deposited as

TABLE V.

Complications.	Number of Cases.
Post-operative stricture	10
Cystitis	16
Incontinence of urine (temporary) .. .	3
Hematuria	2
Obturator neuritis	1
Scrotal abscess	2
Epididymo-orchitis	4
Post-operative clot retention	2
Recto-urethral fistula	1
Post-operative reactionary hemorrhage ..	2
Secondary hemorrhage	3
Extraperitoneal extravasation (death) ..	1
Thrombophlebitis	1
Retropubic abscess	1
Total	49

plaques on the bladder wall, and on two occasions has led to the formation of phosphatic calculi in the bladder. A suprapubic cystotomy was necessary to remove a large phosphatic calculus on one occasion. This condition does not respond to the usual antibiotic and chemotherapeutic measures. It has been treated by frequent bladder irrigations with weak acid solution together with ammonium mandelate mixture and limited fluid intake in an effort to produce acidity of the urine in the bladder. The phosphatic incrustations are soluble in acid urine. The solution most frequently used for irrigation of the bladder has been Suby "G" solution. The basis of this solution is citric acid, magnesium oxide and sodium carbonate, and its reaction is weakly acid.

Since "Chloromycetin" has become available, two patients with chronic alkaline cystitis have been treated by the use of this drug for a period of seven days in each case, and the results have been most gratifying. One of these patients required a second course of a week's treatment before the cystitis had completely cleared.

The retropubic operation, when first demonstrated in this hospital, did not include the resection of a V-shaped portion of the bladder neck on its posterior wall, as

described by Millin. This manoeuvre was not performed in this hospital until twelve months after the operation had been introduced. As a result some cases of post-operative

TABLE VI.
Number of Cases per Year.

Year.	Total.	Deaths.
1947	41	5
1948	31	—
	(+1 readmission for pyelonephritis)	
1949	35	3
	(+1 readmission for agranulocytosis)	

bladder neck obstruction developed, and these cases are included in the series of 10 cases of post-operative stricture. All these patients have required readmission to hospital on at least one occasion for the passage of sounds and dilatation of the stricture, while several of them have been readmitted to hospital on more than three occasions for this purpose. Since the technique of removing a portion of the internal sphincter by a wedge resection in the

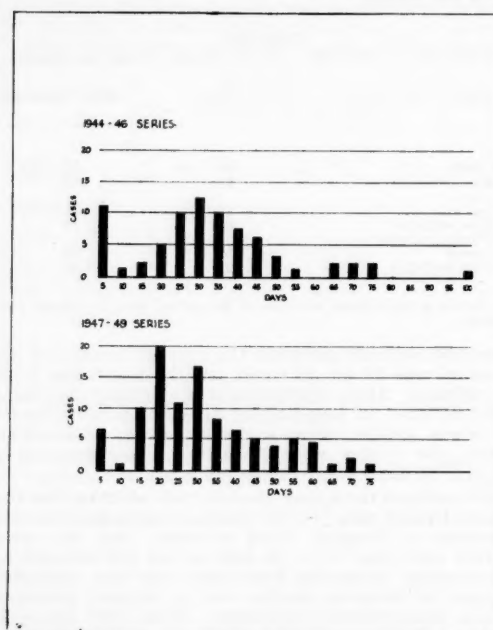


FIGURE 1.

Charts showing post-operative period in hospital. The cases are grouped in five-day periods.

posterior portion has been used, this complication has been practically abolished. Again, it has been the practice of almost every surgeon to enucleate the prostate from its capsule with the finger and to tear through the urethra at the junction of the prostatic and membranous portions of the urethra by a blunt finger dissection. As a result three patients developed temporary incontinence of urine. Two of these have still some loss of control of micturition at times, as evidenced by slight dribbling when the bladder becomes full and if occasion should arise that micturition cannot be accomplished as soon as the desire is present. This complication is due, without doubt, to partial avulsion of some of the membranous portion of the urethra during enucleation of the prostate. It has certainly impressed upon us the importance of dividing the urethra with scissors under vision at this point, as described by Millin.

Two patients developed post-operative reactionary hæmorrhage, sufficient to produce cessation of drainage of the catheter during the first two days after operation, and resulting in the bladder's becoming filled with blood clot. On each occasion it was necessary to evacuate the clot by means of the passage of the resectoscope and by the aspiration of the clot with the Bigelow evacuator.

The three cases of secondary hæmorrhage all occurred between seven and ten days after operation, and were no doubt due to the separation of slough in the prostatic bed, where hæmorrhage had been controlled by electro-coagulation. In the case of extraperitoneal extravasation, a Foley catheter had been used, the bag on the catheter being distended with water, in the prostatic cavity. Although the irrigating fluid ran in through the side tube on the catheter satisfactorily, it did not return through the main catheter. Pressure of irrigating fluid inside the bladder and prostatic cavity caused it to seep through the suture line on the anterior surface of the prostatic capsule, and this fluid was extravasated extraperitoneally up as far as the kidneys, causing the patient's death. Since that time the use of the Foley catheter has been abandoned.

Before bilateral vasectomy was performed as a routine procedure four cases of epididymo-orchitis occurred. Since the occurrence of this complication bilateral vasectomy is performed at every operation and no further cases of epididymo-orchitis have been reported.

Charts showing the post-operative period in hospital in both series of cases are presented (Figure I). The cases have been grouped in five-day periods. Thus, for example, in the 1944-1946 series 12 patients were in hospital from nil to five days after operation, and two patients from five to ten days after operation. All patients in hospital less than 15 days after operation died; and it will be seen, in the 1947-1949 series, that only 10 patients were discharged from hospital within 15 days of their operation. Twenty patients were discharged from hospital between 15 and 20 days after operation, and 17 between 25 and 30 days after operation. There were two patients in hospital between 75 and 80 days after operation. In the 1944-1946 series the number of days has been arranged in a similar manner, and it will be seen that two patients were in hospital between 95 and 100 days after operation. One patient was not discharged till 123 days after operation.

Conclusions.

Our experience at this hospital with this operation over the past three and a half years has led us to believe that, in the hands of general surgeons not practising urology as a sole specialty, the retropubic operation is the operation of choice for prostatectomy. The importance of certain details in the operative procedure has also been impressed upon us. Wedge resection of the posterior wall of the bladder neck appears to be essential to avoid post-operative stricture, while division of the urethra at the junction of the prostatic and membranous portions by scissors appears also to be essential to avoid post-operative incontinence of urine. Bilateral vasectomy performed either before or during operation avoids the complication of epididymo-orchitis.

Summary.

A review of two series of prostatectomy cases is presented and a comparison is made between the results achieved by the retropubic operation with those of the suprapubic and perineal operations performed before the introduction of the former method. The mortality rate and an analysis of the cause of death are presented in both series, and factors contributing to the lower mortality rate in the second series are mentioned.

Complications of the retropubic operation are discussed, and points in technique in performing the operation are considered with a view to preventing the onset of some of these complications. The number of days in hospital after operation in both series is presented.

Reference.

Millin, T. (1947), "Retropubic Urinary Surgery", Chapter IX, page 88.

A NOTE ON HYPOXIA DURING NITROUS OXIDE ANÆSTHESIA IN DENTISTRY.¹

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NITROUS OXIDE is a useful anæsthetic in minor dental operations. It is, however, of low potency. The user is therefore tempted to reinforce its effect by reducing the oxygen percentage of the anæsthetic mixture to sub-atmospheric levels. This questionable technique seems to have survived longer in the sphere of dentistry than in that of general surgery. The writer wished to ascertain the degree of the hypoxia thus produced and its likelihood of doing harm to the patient. The initial difficulty was to devise a method of approach which would enable a fairly large series of cases to be studied and yet be applicable by an anæsthetist working single-handed under the ordinary conditions of practice.

Method of Approach.

The intermittent-flow gas anæsthesia apparatus usually employed for minor dental operations is not necessarily true to scale. It may be inaccurate at its manufacture or it may develop errors due to use. Two such pieces of apparatus were therefore recalibrated by means of the Beckman paramagnetic oxygen analyser. That scale division was first found which indicated delivery of a mixture containing an atmospheric percentage of oxygen—that is, 21%. The values of various scale divisions above and below this critical point were then determined. In consequence, the actual percentage of oxygen delivered for any setting of the dial was thus known with reasonable accuracy. Calibration was repeated at intervals, as was thought necessary. The accuracy of the analyser itself, on each occasion, was checked by trial analyses of pure nitrous oxide, pure oxygen and atmospheric air.

The recalibrated apparatus was used for twelve months in the administration of nitrous oxide and oxygen, by the method of nasal insufflation, for minor dental operations. Induction was commenced in most cases with pure nitrous oxide. Oxygen was added progressively in advance of the clinical signs of hypoxia. Note was made of the highest percentage of oxygen compatible with entry into the third stage of anæsthesia within the usual period of two or three minutes. During the operation, efforts were made to increase this percentage by successive increments to the highest compatible with quiescence. Details of the administrations were recorded upon Nosworthy punch-cards.

The Clinical Material.

The patients handled numbered 339. In three instances the record was incomplete and is therefore omitted from further consideration. The remaining 336 patients ranged in age from two and a half to sixty-five years. They were mostly in good health, being rated as "A-risk" in 320 instances and as "B-risk" in 16. The operations were brief, involving no great trauma or hæmorrhage. The shortest administration lasted for three minutes; the longest, surgical difficulties being present, lasted for twenty-one minutes. The average duration was 7.7 minutes.

Results.

The administrations fell into two classes—namely, those in which unsupplemented nitrous oxide and oxygen anæsthesia sufficed, and those in which volatile supplement was necessary. The former class was again subdivided into three groups, as follows: (i) those in which the final percentage of oxygen lay below 15; (ii) those in which it lay between 15 and 20; (iii) those in which anæsthesia was attained with oxygen percentages in excess of 20. The basis for this arbitrary subdivision will become apparent from a later paragraph. The distribution of the various groups is shown in Table I.

¹Read at a meeting of the Australian Society of Anæsthetists at Sydney on February 23, 1951.

It is at once apparent that only the exceptional patient entered the third stage of anaesthesia, if supplied almost from the beginning with an atmospheric percentage of oxygen. Consciousness was abolished, of course, but quiescence and muscular relaxation failed to ensue within the two or three minutes assigned to the induction. Surgical anaesthesia would doubtless have supervened had the patient been exposed to the mixture for ten or fifteen minutes, as in general surgical operations. An induction of this duration is, however, incompatible with the requirements of minor dental operations. It was therefore necessary either to restrict the supply of oxygen or to resort to volatile supplement.

TABLE I.

Type of Anaesthesia.	Number of Cases.	Percentage of Cases.	Average Duration of Administration. (Minutes.)
Unsupplemented nitrous oxide and oxygen:			
Oxygen percentage below 15	43	12.8	6.5
Oxygen percentage from 15 to 20	92	27.5	6.7
Oxygen percentage 21 or over	12	3.6	7.9
Volatile supplement	189	56.1	8.5
Total	336	100.0	7.7

Limitation of the percentage of oxygen to a figure below 15 is not recommended, but was carried out in 43 cases in this series, either because the operation was to be very brief, or merely to allow the result to be observed. Minor degrees of hypoxia, with an oxygen percentage of 15 to 20, were permitted on 92 occasions. In a further 189 cases it was obvious that the third stage of anaesthesia could be reached only by gross restriction of the supply of oxygen. Accordingly the percentage was kept at the atmospheric level, and the necessary potency was secured by a small addition of trichlorethylene or of ether. When surgical anaesthesia was reached, the percentage of oxygen was increased to 25 or 30. This course was adopted uniformly for resistant subjects and for small children, the high metabolic rate of the latter rendering them difficult subjects for unsupplemented nitrous oxide and oxygen anaesthesia.

Discussion.

In the course of experiments carried out upon the writer by Dr. D. G. Renton and Dr. R. H. Orton, samples were withdrawn from the right stem bronchus during inhalation of a mixture containing 85% of nitrous oxide and 15% of oxygen. These samples must have approximated closely in composition to alveolar air. They were found to present an oxygen tension of the order of 65 millimetres of mercury. Reference to the dissociation curve of haemoglobin shows this tension to correspond with approximately 87% saturation of the arterial blood. Oxygen unsaturation of 13% is probably of no great significance, provided that (a) the anaesthetic is, like nitrous oxide, only weakly histotoxic, (b) the subject is healthy, and (c) the administration is brief. The dissociation curve shows, however, that further reduction of the oxygen percentage in the atmosphere to values below 15 is accompanied by a sharp decline in the saturation of the blood. It is for this reason that 15% of oxygen was taken in this series as a critical figure; it is probable, indeed, that less should never be presented to any patient.

It would seem from this series that, under ordinary conditions of minor dental surgery, it is only the exceptional patient who enters surgical anaesthesia when receiving an atmospheric percentage of oxygen. The anaesthetist must then decide whether he will work at sub-atmospheric levels or, maintaining the atmospheric level, will resort to volatile supplement. The former course has been adopted widely in the past. That harm has seldom accrued is testimony to the relative freedom of nitrous

oxide from histotoxic effect. A minor degree of hypoxia will probably not harm a healthy subject provided that the percentage of oxygen supplied is 15, that no volatile agent is introduced, that the air passages are patent and that the duration of anaesthesia is limited to about five minutes. Such technique is, however, of a marginal nature. It seems more reasonable to give an atmospheric percentage of oxygen, making up any defect in potency by means of volatile supplement.

The use of supplement is alleged by some to prolong recovery and to increase the incidence of after-sickness. This may be doubted if the volatile agent is truly supplementary and not the main agent with nitrous oxide and oxygen as its vehicle. Some evidence for this statement is to be found in the present series. The latter was not large enough to make it worth while to analyse the incidence of vomiting in the several groups of cases. It was possible, however, to compare the summed figures for unsupplemented nitrous oxide and oxygen anaesthesia with those for the supplemented form. The results are shown in Table II.

TABLE II.

Nitrous Oxide and Oxygen Anaesthesia.	Number of Cases.	No Vomiting.	Slight Vomiting.	Moderate Vomiting.	Severe Vomiting.
Unsupplemented	97	65 (67.0%)	29 (30.0%)	1 (1.0%)	2 (2.1%)
Supplemented	127	82 (64.5%)	40 (31.5%)	4 (3.1%)	1 (0.8%)

The figures in this small series do not, therefore, indicate any material excess in the incidence of post-anaesthetic vomiting when volatile supplement is employed. Figures collected by the writer in the past seven years suggest that the incidence of vomiting after trichlorethylene supplement is slightly less than that after ether.

Conclusions.

1. It seems rarely possible, under ordinary conditions of minor dental surgery, to induce and maintain anaesthesia with nitrous oxide when the percentage of oxygen is atmospheric.

2. Reduction of the percentage of oxygen below the atmospheric level must be undertaken circumspectly, if at all. The percentage of oxygen should not fall below 15; the patient should be healthy, with patent air passages; volatile supplement should not be employed and the administration should be brief.

3. It is probably wiser to maintain always a percentage of oxygen equal to, or slightly in excess of, the atmospheric level. Anaesthetic potency must often be supplied, in this event, by means of minimal volatile supplement.

4. The use of volatile supplement does not appear to add materially to the incidence of post-anaesthetic vomiting.

Reports of Cases.

METHAEMOGLOBINÆMIA DUE TO ANILINE.

By S. E. L. STENING, M.B., B.S., D.C.H., M.R.A.C.P.,
Sydney.

METHAEMOGLOBINÆMIA is not an uncommon condition. It is encountered in industrial medicine, particularly in dye manufacturing and chemical works. In these places preventive measures are used and the danger is well recognized. It was frequently seen in the early days of sulphonamide medication.

Methaemoglobinæmia can be the result of continued absorption of small doses of poison—whether it be aniline, aniline derivative, nitrite, nitrate or phenacetin group, but

it can also result from a large dose of the noxious agent leading to the development of acute methæmoglobinæmia, which may be fatal.

Methæmoglobinæmia due to aniline is most unusual in pædiatric practice, although methæmoglobinæmia affecting infants, who are usually less than three months of age and who have been given a milk mixture made with water containing a high percentage of nitrate or nitrite, or both, is well known. A recent report by Lecks (1950) indicates at least 33 cases due to the presence of high percentages of nitrate and nitrite in well-water.

Aniline poisoning causing methæmoglobinæmia due to the ingestion of coloured wax crayons is referred to by Lecks, but I have found no report of a case of acute aniline poisoning in school children caused by the pure chemical.

Clinical Record.

N.M., aged fourteen years, a schoolboy attending one of our great public schools, entered the chemistry laboratory for a lesson at 1 p.m. on March 23, 1950. He noticed a colourless liquid on the seat and wiped it up with a rag supplied for the purpose. Then he sat down. At 1.15 p.m. he noticed his seat becoming warm and sticky, so he wiped the seat again with his handkerchief, which was replaced in his pocket. By 1.45 p.m. there was a brown patch on his trousers, but the master did not consider that any treatment was warranted. At that time the boy moved to a different classroom and there again the seat became warm and sticky. At 2.35 p.m. he experienced the first symptom—a headache. At 3 p.m. he was told by some six boys that he was becoming blue around the mouth and that his face was white.

School ended at 3.15 p.m. and by now his head was throbbing. At 3.25 p.m. the boy noticed that he could not walk steadily, but that he was still clear in his mind. Till 4 p.m. he prepared a speech with his debating team-mates, and till 4.45 p.m. he listened to other speakers in the debate. When his turn to speak came he mounted the platform and attempted to walk to the speaker's box, but he found it impossible to control his feet, so that he lurched and stumbled. On reaching the speaker's box he dramatically collapsed, helpless, though he was still conscious of what went on around him.

He was immediately placed on a stretcher and taken to the school hospital, where he vomited. From then on his mind is blank except for a short period, in the open air, when he was carried to an ambulance and was aware of a tube in his left nostril.

The boy was first examined by me at approximately 5.30 p.m. He lay on a bed in the school hospital, apparently unconscious, his lips and ears deeply cyanosed and the remainder of his face showing pronounced greyish pallor. There was no distress, the respirations were even but not laboured. His pulse had a rate of 84 per minute and was regular. The heart was enlarged, the apex beat being in the sixth intercostal space, three-quarters of an inch outside the nipple line, and loud, blowing systolic murmurs were audible at all areas. Though this boy had been examined at intervals in the past fourteen years, murmurs in his heart had never been detected.

Reflexes were present and his pupils reacted to light; they were neither dilated nor contracted. He could be roused and replied to questions quite clearly and rationally. He related how he had sat on the wet seat, though he did not know what the material was. He laughed heartily as he told of the seats becoming sticky. He then vomited and lapsed back into a stuporose condition.

He was then transferred to a private hospital. *En route* by ambulance, oxygen was administered, and this was continued at the hospital. Oxygen made not the slightest impression on his cyanosis. The next one and a half hours were spent in endeavouring to obtain some methylene blue for treatment. No chemist in the district could supply the drug, and two large metropolitan hospitals also disappointed when appealed to for some methylene blue.

By this time the boy was sweating and was vomiting frequently and copiously. His pulse rate had increased

to 120 per minute. There was still no respiratory distress. He was less easily roused and could not be prevailed upon to speak. A coffee enema was given.

At about 8.30 p.m. a consultation was held, since the boy was now deeply comatose and could not be roused and was having twitching movements of the limbs, suggestive of cerebral irritation and apparent approach of death. It was suggested that a replacement transfusion should be given.

Before this could be arranged, and at approximately 9 p.m., the private hospital, through its own chemist, procured some methylene blue, and so the injection of 100 milligrammes in 20 millilitres of sterile water was begun slowly into the right median cubital vein.

After a few seconds of the injection the boy twitched, raised his head, gurgled and gagged. Was this death? No, for on rapid completion of the injection he opened his eyes, looked around, said "good-night" and then dropped off to sleep.

Five minutes later he woke again, talking rationally and apparently normal mentally, but still with slight cyanosis. A few minutes later still the loud apical murmurs had gone, though the basal murmur remained, and his heart was smaller. Rapid recovery continued as we watched.

Since there was some slight residual cyanosis a further injection of 150 milligrammes of methylene blue in 30 millilitres of sterile water was given intravenously, resulting in complete clearing of the cyanosis.

From this point full recovery was uneventful, though he still felt tired and weak for a further seven days. The results of serial blood counts remained normal for the ensuing fortnight. Cardiac and electrocardiographic evaluation on April 7 revealed a pulmonary systolic murmur, but no other abnormality. Mental evaluation of this patient showed no abnormality after the second day, except for the hiatus in his memory mentioned above.

Comment.

Several points require further mention in this case.

1. Chemistry classes in our schools require careful control by a master who should be familiar with the dangers of the materials used and proficient in methods of first-aid treatment.
2. Practical jokes by schoolboys with chemicals should be actively discouraged.
3. Dangerous and potent chemicals, such as aniline, should not be allowed in school classrooms. Aniline is a colourless liquid which turns brown on exposure to air. It is volatile and may be inhaled. In this case the patient apparently sat in a localized atmosphere of vaporizing aniline (on his trousers) for some three hours before he collapsed. A contaminated handkerchief was in his pocket, and he probably had some of the material on his fingers, which may have been conveyed to his mouth. The summation of the exposures was sufficient to bring him nigh to death.
4. If such a potent chemical does come in contact with clothing, then it should be mandatory that that clothing be removed and that the body should be washed under a shower.
5. Methylene blue should be generally available for instant use in such cases. Delay in obtaining supplies in this case was fraught with danger both to the boy's life and to his grey matter.
6. It is noteworthy that the boy's grey fountain pen has now become a rather dirty shade of green, indicating the penetrating power of the aniline vapour.

Acknowledgements.

I should like to express my appreciation to Dr. A. W. Morrow and Dr. J. B. Walsh, of the Red Cross Blood Transfusion Service, for their valued assistance with this case.

Reference.

- Lecks, H. J. (1950), "Methemoglobinæmia in Infancy", *American Journal of Diseases of Children*, Volume LXXIX, page 117.

Reviews.

BROAD VIEWS ON SEX-WORSHIP.

THE Emeritus Professor of Semitic Languages and Literatures in the University of Manchester offers a short commentary on the views of less ancient peoples about sex, and bestows a half-hearted blessing on the second reprint of Mr. H. Cutner's book "A Short History of Sex-Worship".¹ His introductory foreword, however, merely describes the author as "a pictorial artist as well as a serious student of religious symbolism", without giving the reader the slightest indication of his status as an authority on the subject. He then leaves the author to his own devices by saying in conclusion that "he offers also many conjectures of his own, for which, of course, he alone is responsible".

While it is admitted that ancient peoples set great store by symbolisms that seemed to contain the essence of life-giving properties, and so might be helpful in promoting fertility, productivity and general prosperity that would benefit the tribe, it is extremely doubtful whether representatives of the ruling class at any period in ancient history ever were greatly obsessed with the importance of sex-symbolism, as the writer seems inclined to suggest. In fact, some anthropologists stoutly deny that phallicism was a dominant religious cult with earlier civilizations. However, it must be conceded that since the pre-Christian era a form of sex-worship has enjoyed a certain popularity among the more degenerate section of various communities in the form of ritual sex-orgies and Bacchanalian feasts, which frequently ended in such licentiousness that the political authority was forced to outlaw the proceedings as prejudicial to the best interests of the State.

It is difficult to discern the substance, when so many shadows keep flitting across the pages of this book.

GASTRO-ENTEROLOGY.

A POST-GRADUATE COURSE in gastro-enterology was held under the aegis of the American College of Physicians during a week in December, 1948, in Philadelphia, and one result of this has been the publication, under the editorship of Henry L. Bockus, of "Postgraduate Gastroenterology".²

The presentations were in the form of symposia often followed by panel discussion, and in some instances cases were demonstrated and clinical conferences were included. All of these have been most carefully assembled and arranged by Dr. Bockus.

The common symptom, pyrosis, receives due consideration as evidence of an oesophageal disturbance and the importance of eating habits and of personality problems in its production is well substantiated. Descriptions of radiological examinations in the diagnosis of oesophageal lesions and of surgery as applied to lesions of the thoracic part of the oesophagus are well illustrated.

Gastric secretion is considered in the light of effects of para-sympathetic-mimetic drugs, and a warning is given that "Prostigmin" should not be used after bilateral vagotomy because, being an anticholinesterase, it inhibits gastric motility which is already depressed. Dibutoline has been tested and found useful in inhibiting secretion of gastric juice during the night, but it must be injected to be effective, its action is of short duration (shorter than that of atropine) and it has little if any advantage over atropine. F. Hollander discusses the secretion of gastric mucin in health and in disease, and illustrations of the very rapid onset of "resurfacing" of gastric mucosa after complete denudation are convincing. Gastric analysis and the procedures and fallacies in connexion therewith are discussed with particular reference to acidity after injection of histamine. Estimation of pH of gastric secretion is necessary to exclude secretion of acid.

In the panel discussion Dr. Hollander states that he is doubtful whether vagotomy interferes with secretion of

mucus; and there is no evidence of neural innervation of mucous glands in the stomach.

Gastric neoplasms receive the full consideration which their importance merits.

The radiographic diagnosis of post-bulbar duodenal ulcer is dealt with in detail by A. Finkelstein. The effects of vagotomy in depressing gastric secretion and motor function, and the present status of vagotomy from surgical and medical aspects are discussed. Bockus concludes that if it eventually proves to be of some benefit it will be used in conjunction with some other surgical procedure such as partial gastrectomy to avoid gastric stasis. Vagotomy is still an experimental procedure. Partial gastrectomy and the "dumping" syndrome are considered.

The application of neuro-psychiatry to gastro-intestinal disorders is presented by S. Wolf, followed by E. Weiss, and others submit personality studies and reports on disorders in psychotic reactions.

Allergy and endocrine disorders affecting the alimentary tract are considered. A symposium on the pancreas deals with physiology, the value of estimation of serum amylase and lipase in the diagnosis of pancreatic lesions, experience with pancreatic stimulants, of which secretin and urecholine have effect, and the diagnosis and treatment of acute pancreatitis.

In carcinoma of the pancreas attention is directed to the high incidence of pain which is next in frequency to loss of weight. It occurs at some time in 76% to 83% of cases. Painless jaundice, although of diagnostic value, is not characteristic of most cases.

Symposia on abdominal pain, the liver, hepatitis, tests of liver function, non-specific enteritis and entero-colitis, intestinal obstruction, chronic ulcerative colitis and carcinoma of the colon are also presented. Lysozyme receives full consideration. Valuable discussions on the mode of action of drugs on the autonomic nervous system, the differential diagnosis of jaundice, the post-cholecystectomy syndrome, and biliary dysynergia could be read with advantage by all who are interested in internal medicine.

This book is excellently produced and is of the type which will appeal particularly to experienced physicians and to those studying for higher medical degrees, as one of the best publications on the subject.

PHYSIOLOGY AND BIOCHEMISTRY.

A NEW text-book of physiology and biochemistry has been produced by the collaboration of the Professor of Physiology in the University of St. Andrews, the Professor of Physiological Chemistry in the University of Glasgow and the Professor of Medicine in the Welsh National School of Medicine.³ Such an undertaking would be almost impossible for a single individual in the present era of specialization. The book is very well produced. The numerous diagrams and plates which illustrate the text are beautifully clear, and the type is pleasing to read. Although there is no attempt to separate physiology from biochemistry, the first part of the book deals mainly with biochemistry such as the chemistry of the foodstuffs, enzymes, vitamins, digestion, nutrition and metabolism, while the second part is mainly an account of the physiology of blood, circulation, respiration, kidney, nervous system and endocrine glands. The authors' main object in writing yet another text-book of physiology has been to produce an introduction to the study of physiology and biochemistry for medical students. The student will find in this book many facts clearly written. Should he wish to pursue any subject further, there are some references at the end of each chapter. These references are usually to reviews and monographs which are excellent in themselves. In the teaching of physiology, however, it is essential to encourage the student to refer to some of the classical original papers. By so doing he can find out for himself how our physiological concepts have arisen, and so develop a more critical mind. It is a pity, therefore, that the authors have not given more references to original papers. The book is also intended for the medical graduate. It is becoming more and more desirable that the medical graduate, in whatever field he may work, keeps up to date as far as possible with the rapid advances in physiology and biochemistry. The problems

¹ "A Short History of Sex-Worship", by H. Cutner; 1950. London: C. A. Watts and Company, Limited. 7½" x 5", pp. 222. Price: 2s. 6d. (paper binding) and 5s. (cloth binding).

² "Postgraduate Gastroenterology: As Presented in a Course Given Under the Sponsorship of the American College of Physicians in Philadelphia, December, MCMXLVIII", edited by Henry L. Bockus, M.D.; 1950. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9½" x 6½", pp. 690, with 258 illustrations. Price: £4 15s.

³ "Textbook of Physiology and Biochemistry", by George H. Bell, B.Sc., M.D. (Glasg.), F.R.F.P.S.G., F.R.S.E., J. Norman Davidson, M.D., D.Sc. (Edin.), F.R.F.P.S.G., F.R.I.C., F.R.S.E., and Harold Scarborough, M.B., Ph.D. (Edin.), F.R.C.P.E., with a foreword by Robert C. Garry, M.B., D.Sc. (Glasg.), F.R.F.P.S.G., F.R.S.E.; 1950. Edinburgh: E. and S. Livingstone, Limited. 9" x 6½", pp. 936, with many illustrations. Price: 45s.

that confront the clinician in the wards have often to be considered in terms of the basic sciences. Here is a book which gives a short but clear and authoritative account of this whole field. It could profitably be read by all medical graduates.

SURGICAL ANATOMY.

LEE MCGREGOR'S "Synopsis of Surgical Anatomy" has reached its seventh edition in eighteen years.¹ Little more need be said of its popularity.

There are several improvements in this edition; these include Milligan's observations on the ano-rectal region and new chapters on transthoracic surgery and on the surgery of the blood vessels. The section on the sympathetic nervous system has been improved, but there is no mention of the anterior approach by the modified method of Fey, advocated by Stock, of Liverpool, and becoming more popular.

There is no mention of the important work of Flolke and Delmas on the exposure of main arteries.

Needlessly mutilating incisions are recommended for the hand, and insufficient attention has been paid to the work of Iselin and Bunnell.

There are still some errors, such as the old cadaveric idea about the length of the small bowel, and the statement that azygos means median.

COMMON DISEASES OF THE EAR, NOSE AND THROAT.

IN "Common Diseases of the Ear, Nose and Throat" the author, Philip Reading, has produced a book which is suitable for the undergraduate and for the general practitioner.² It is not intended to be a book of reference for the specialist.

This small volume is confined to essential facts. Operative techniques have been afforded but little space, whereas complications of operations such as tonsillectomy and tracheotomy have been described at some length. Although the description of anatomy has been reduced to a minimum, the diagrams are very clear. These two factors tend to "spot light" those structural details, which are of importance in diagnosis and treatment. They succeed in linking the manifestations of diseases with aberrations of the underlying structure and function of the ear, nose and throat.

The paper, print and illustrations are good and the context is very clear. Unfortunately no short list of references covering recent literature has been included at the end of the chapters. This would have been very useful to newly qualified practitioners.

CURRENT THERAPY.

THE first edition of "Current Therapy, 1949: Latest Approved Methods of Treatment for the Practicing [sic] Physician" was reviewed in this journal on October 29, 1949. The 1950 edition has now appeared.³ Dr. Howard F. Conn is again the editor. The general plan was outlined in the previous review. The editor reemphasizes that this is not a "review of the literature" or "recent advances" type of work, but rather a record of procedure actually carried out by the contributing physician. The reader is, as it were, admitted by proxy to the practice of many well-known American clinics.

As expected, knowledge of the newer antibiotics has required a complete revision of the section on infectious

¹"A Synopsis of Surgical Anatomy", by Alexander Lee McGregor, M.Ch. (Edin.), F.R.C.S. (England), with a foreword by Sir Harold J. Stiles, K.B.E., F.R.C.S. (Edin.); Seventh Edition; 1950. Bristol: John Wright and Sons, Limited. London: Simpkin Marshall, Limited. 4½" x 7¼", pp. 796, with 746 illustrations. Price: 25s.

²"Common Diseases of the Ear, Nose and Throat", by Philip Reading, M.S. (London), F.R.C.S. (England); 1950. London: J. and A. Churchill, Limited. 8" x 5½", pp. 298, with 37 illustrations. Price: 21s.

³"Current Therapy, 1950: Latest Approved Methods of Treatment for the Practicing Physician", edited by Howard F. Conn, M.D.; 1950. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 10½" x 8", pp. 770. Price: £4 15s.

diseases. It is strange that, although meningococcal infection is fully dealt with, the important influenza, pneumococcal and tuberculous meningitides are scarcely mentioned. Among other established discoveries vitamin B₁₂ now receives full recognition, and a few others have found their place. As before, most sections make a good impression; a few do not. In *status epilepticus* one author advises a totally inadequate dose of sodium phenobarbital intramuscularly and its repetition in two hours. The role of parenterally administered paraldehyde is not yet appreciated. Two contributors mention its intravenous use in *status epilepticus* and tetanus respectively. Neither mentions the necessity for, and method of, its solution. Intravenous use of "Etamon" is still advocated, on very questionable grounds, for certain cases of acute coronary insufficiency.

The careful practitioner would thus still do well to satisfy himself of the safety of some of the measures proposed before accepting them as they stand. Read in this critical spirit, the book will offer him much that is helpful. Type and arrangement are, as before, excellent. The price and the difficulty, inherent in such a work, of striking a balance between up-to-dateness and avoidance of unproved methods, may make the reader hesitate to add the book to his library every year. He might conclude that, with other reading, every two years would do.

PREFRONTAL LEUCOTOMY.

MAURICE PARTRIDGE has produced a most interesting monograph in "Pre-Frontal Leucotomy", which represents a personal survey of 300 patients followed over periods ranging from one and a half years to three years.⁴ This review is probably unique, since all patients were operated on by Mr. Wylie McKissock and all were interviewed by Partridge at periods of six months, twelve months and two years after operation. This considerable task involved visits to more than thirty different hospitals and institutes requiring a total travelling distance of more than 60,000 miles.

Complications and sequelae are considered after a short preliminary account of operative technique. The results, in different groups of clinical material, are then objectively assessed to include the short range and long range changes in cases of affective disorder, schizophrenia, obsessional states, psychopathic personality, drug addiction, mental defect and disorder associated with organic disease. The work concludes with an extensive bibliography which provides reference to reviews of the literature, individual articles, operative techniques, psychological tests and anatomical, physiological and pathological observations.

The book is an excellent production, the subject matter being set out to make possible easy reference to particular case groups. Partridge's style is both fluent and precise. The book should be read by everybody interested in the surgical treatment of psychiatric disease and will probably remain the standard text on this special subject for some years.

RADIATION THERAPY IN CARCINOMA OF THE CERVIX.

ANYONE who is called upon to treat cancer of the cervix will find much of interest and value in Simeon T. Cantril's recent monograph⁵ dealing with radiation therapy in the management of this disease.

Pathological considerations include the new concept that epidermoid cervical cancers have a dual ancestry. Pre-invasive carcinoma is recognized, but only as a microscopic diagnosis and giving no indication of the actual clinical stage. The author estimates that pelvic metastases may be expected in 15% to 20% of Stage I cases and repeatedly emphasizes that control by irradiation of cancer in the lymph nodes must be extremely rare. The point is made that radiation therapy can never be a matter of slavish routine; each case presents an individual problem and treatment must be adjusted to the patient's general condition and to

⁴"Pre-Frontal Leucotomy: A Survey of 300 Cases Personally Followed over 1½-3 Years", by Maurice Partridge, M.A., D.M. (Oxon.), D.P.M. (England); 1950. Oxford: Blackwell Scientific Publications. 8½" x 5½", pp. 504. Price: 42s.

⁵"Radiation Therapy in the Management of Cancer of the Uterine Cervix", by Simeon T. Cantril, M.D.; 1950. Illinois: Charles C. Thomas, Oxford: Blackwell Scientific Publications, Limited. 8½" x 5½", pp. 212, with many illustrations. Price: 36s.

existing complications. The Stockholm, Paris and Manchester techniques are briefly described together with the role of transvaginal therapy and problems of dosimetry. The immediate and remote complications of therapy are well surveyed. Then follows a discussion on the reasons for failures in Stage I cases, after which is presented a comprehensive statistical summary of the results from world-wide sources of the highest repute. The treatment of carcinoma of the cervical stump is reviewed, together with the results from four centres, and a chapter is devoted to the management of cervix cancer complicated by pregnancy.

One of the two appendices sets out, with numerous diagrams, the League of Nations classification of clinical staging, and the book concludes with a list of 120 references covering innumerable aspects of the subject.

The therapist will devour this book with great relish. As for the clinical gynaecologist, although in parts the discussion becomes a little too technical, and granted that many of the tables given will be unintelligible to him, the general principles of radiation therapy so clearly enunciated will greatly enhance his understanding of the treatment of this and other cancerous conditions in which collaboration between therapist and surgeon is all-important.

Although dealing specifically with cancer of the cervix, the book is, in effect, a review of the potentialities of radiant energy in the treatment of all forms of malignant disease. It is also much more than just a technical monograph for the radiophysicist; every doctor, specialist or otherwise, who deals in any way with patients suffering from carcinoma of the cervix, will derive something of benefit from its perusal.

SURGICAL PROCEDURES.

"TECHNIQUES IN BRITISH SURGERY", edited by Rodney Maingot, is without doubt an important contribution to the science and art of surgery. It comprises a series of specially selected articles by twenty-nine of Britain's leading practising surgeons, each a recognized teacher and leader in thought on the subject he has chosen. The techniques described are based on sound principles and proven by wide experience.

In the articles, operative procedures are beautifully illustrated and important details are clearly depicted. However, there is more than just operative technique in the articles, for the wealth of knowledge and experience behind them pervades the text, and one finds much useful information on such things as pre-operative and post-operative management, choice of operative procedures and the end-results of these.

The subject matter is arranged in four parts, the sections being as follows.

Part 1: "Head, Neck and Spinal Column." Amongst the articles is one on "Head Injuries in Civil Life", another on "Spinal Tumours", and a comprehensive article on the "Surgery of the Thyroid Gland".

Part 2: "Thorax." In this section are two detailed articles on the "Techniques of Pneumonectomy" and the "Surgical Treatment of Pulmonary Tuberculosis" as well as several others.

Part 3: "Abdomen and Pelvis." Here one finds that subjects covered include the management of "Acute Intestinal Obstruction" and surgical considerations in "Peptic Ulcer", and a discussion on "Inguinal and Femoral Hernia". There are articles on certain aspects of rectal and prostatic surgery, one on "Carcinoma of the Pancreas", and Maingot himself writes on "The Surgical Aspects of Cardiospasm". There are many other well-written and well-illustrated articles in the section.

Part 4: "Extremities." In this section the articles are of orthopaedic interest, except one on "Acute Infection of the Hand", and another on "The Management of Senile and Diabetic Gangrene".

"Techniques in British Surgery" will appeal to all interested in surgery, for it is, as the editor intended, a liberal cross-section of British surgery as practised today. As surgeons have described and illustrated some of their operative procedures in such detail, it helps to bridge the gaps of time and distance which tend to isolate us from our surgical colleagues in Great Britain.

"Techniques in British Surgery", edited by R. Maingot, F.R.C.S.; 1950. Philadelphia and London: W. B. Saunders Company. Melbourne: W. Ramsay (Surgical) Proprietary, Limited. 9½" x 6½", pp. 760, with many illustrations. Price: 17 2s. 6d.

Books Received.

[The mention of a book in this column does not imply that no review will appear in a subsequent issue.]

"Help Yourself to Better Sight", by Margaret Darst Corbett; 1951. Kingswood, Surrey: The World's Work (1913) Ltd. 7½" x 5½", pp. 239. Australian retail price: 12s. 3d.

Advances the view that relaxation is the secret of the art of seeing.

"Pharmacology of the Failing Human Heart", by John McMichael, M.D., F.R.C.P.; 1950. Oxford: Blackwell Scientific Publications. 8½" x 5½", pp. 71. Price: 8s. 6d.

The author, who is professor of medicine at the Post-Graduate Medical School of London, reviews the subject in the light of new knowledge.

"A Text-Book of X-Ray Diagnosis by British Authors", in four volumes, edited by S. Cochran Shanks, M.D., F.R.C.P., F.F.R., and Peter Kerley, M.D., F.R.C.P., F.F.R., D.M.R.E.; Second Edition, Volume II; 1951. London: H. K. Lewis and Company, Limited. 9½" x 6½", pp. 716 with 605 illustrations. Price: 65s.

Deals with the cardio-vascular and respiratory systems.

"The Conquest of Malaria", by Dr. Jaime Jaramillo-Arango; 1950. London: William Heinemann (Medical Books), Limited. 8½" x 5½", pp. 142, with many illustrations. Price: 21s.

The author's aim is to recall the historical struggle against malaria and to record the names of pioneers who have contributed to knowledge of the disease and its treatment.

"Primer on Fractures", prepared by the Special Exhibit Committee on Fractures in cooperation with the Committee on Scientific Exhibit of the American Medical Association; Sixth Edition; 1951. New York: Paul B. Hoeber, Inc. 9½" x 6", pp. 121, with illustrations. Price: \$2.00.

Illustrates the principles of treatment of fractures as demonstrated by the annual exhibits held under the auspices of the Special Exhibit Committee of the American Medical Association.

"The 1950 Year Book of the Eye, Ear, Nose and Throat" (November, 1949-October, 1950); The Eye, edited by D. Vail, M.D., D.Oph., F.A.C.S.; The Ear, Nose and Throat, edited by S. J. Crowe, M.D., with the collaboration of E. W. Hagens, M.D.; 1951. Chicago: The Year Book Publishers, Incorporated. 7½" x 5½", pp. 446, with illustrations. Price: \$5.00.

One of the "Practical Medicine Series" of Year Books.

"Technique of Psychoanalytic Therapy", by Sandor Lorand, M.D.; 1950. London: George Allen and Unwin, Limited. 8½" x 5½", pp. 260. Price: 12s. 6d.

Based on an advanced seminar and colloquium in technique given by the author at the New York Psychoanalytic Institute.

"Experimental Physiology for Medical Students", by D. T. Harris, M.D., D.Sc., F.Inst.P., H. P. Gliding, M.A., M.D., and W. A. M. Smart, B.Sc., M.B., B.S.; Fifth Edition; 1951. London: J. and A. Churchill, Limited. 9½" x 6½", pp. 313, with 266 illustrations and plate in colour. Price: 21s.

Experiments designed to cover the whole field except as it is limited by costliness of apparatus and time.

"The Journal of Mental Science (The British Journal of Psychiatry): Recent Progress in Psychiatry", by authority of the Royal Medico-Psychological Association, edited by G. W. T. H. Fleming in collaboration with Alexander Walk and P. K. McCowan, Second Edition. London: J. and A. Churchill, Limited. 9" x 6", pp. 717. Price: 50s.

A "special issue" of *The Journal of Mental Science*.

"Malignant Disease of the Female Genital Tract", by Stanley Way, M.R.C.O.G.; 1951. London: J. and A. Churchill, Limited. 8½" x 5½", pp. 278, with 38 illustrations. Price: 24s.

Intended primarily for those practising gynaecology.

The Medical Journal of Australia

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All articles submitted for publication in this journal should be typed with double or treble spacing. Carbon copies should not be sent. Authors are requested to avoid the use of abbreviations and not to underline either words or phrases.

References to articles and books should be carefully checked. In a reference the following information should be given without abbreviation: surname of author, initials of author, year, full title of article, name of journal without abbreviation, volume, number of first page of the article. If a reference is made to an abstract of a paper, the name of the original journal, together with that of the journal in which the abstract has appeared, should be given with full date in each instance.

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THE MEETING OF THE FEDERAL COUNCIL.

THE meeting of the Federal Council reported in this issue marks the beginning of another epoch in its life. The Federal Council and its predecessor, the Federal Committee of the British Medical Association in Australia, have had four presidents. The late Sir George Adlington Syme was succeeded by Sir Henry Simpson Newland, who retired in 1949 after many years of service, and with expressions of gratitude and appreciation ringing in his ears. He was succeeded but two years ago by Sir Victor Hurley, or as he then was, Mr. Victor Hurley. Sir Victor Hurley seems to have been destined to become President of the Federal Council, for more than one person "saw him afar off" and named him for the post. He brought to the task a reputation for administrative ability, for thoroughness and for determination. In addition to the fortiter in re he had a full measure of the suaviter in modo. The late Sir Neville Howse, who was in charge of the Australian Army Medical Corps overseas in World War I, singled out Victor Hurley early in the piece as one to whom the reins of administration could be entrusted. Those who served with him know how well he acquitted himself. No one was in the least surprised when, in the 1939-1945 war, he was given control of the medical service of the Royal Australian Air Force. It was while he was serving as director-general of this service that he was looked upon as the future president of the Federal Council. His recent knighthood in the Most Excellent Order of the British Empire was regarded far and wide as a richly deserved honour. Most readers probably know that Sir Victor Hurley is president of the Royal Melbourne Hospital, and he is president-elect of the Royal Australasian College of Surgeons. In the circumstances we can well understand that he wished to seek relief from some of his burdens. As Dr. H. R. R. Grieve remarked at the meeting of the Federal Council, Sir Victor Hurley's presidency has covered anything but a placid period of time, and the achievements of the last year or two are in no small measure due to his wise guidance. Fortunately,

though Sir Victor Hurley relinquishes the position of president, he still remains a member of the Federal Council, and the profession in Australia will still have the benefit of his wisdom. The president of a body like the Federal Council, if he is to be successful, must be gifted with qualities of leadership in his own profession, and must be recognized by its members as possessing them. In addition, he must be a person of standing in the community, known in the world of human affairs as one gifted in the unravelling of tangled skeins and to be reckoned with when new ventures have to be undertaken. In the person of the new President, Dr. A. J. Collins, the Federal Council has found such a man. Though he is known best of all in New South Wales as a counsellor of unusual ability, he is known and respected in every State of the Commonwealth. He says what he means and he means what he says, and his words and works proclaim his sincerity. The Federal Council and the profession throughout Australia can look forward to a period of sound guidance under the presidency of Dr. Collins.

An unusual event in the course of the recent meeting was the conference with Senator the Honourable W. J. Cooper, Minister for Repatriation. Senator Cooper has been known to members of the medical profession for many years on account of his membership of the Parliamentary Joint Committee on Social Security, which took evidence in different parts of Australia some years ago. The opportunity to lay before the Minister the burning question of the increasing manifestation of lay control in medical matters in the administration of his department was one of which the members of the Federal Council were glad to avail themselves. The statement of the Minister that the Repatriation Commission had changed its set-up in the last few years was not particularly reassuring. The change undoubtedly lies in the inroads by the Public Service Board, and it is of these very inroads that the medical profession complains, and with every justification. Decisions in the medical sphere of such a department as that of repatriation are made by medical men, primarily because of their medical knowledge, and to make just decisions calls for years of medical training and experience. To allow these decisions to be overruled by a layman because he holds an administrative position is typical of the worst forms of bureaucracy. The outsider may say that in objecting to this process the medical profession is merely standing up for its dignity. It is true that when a ukase by a layman with no medical knowledge supersedes the premeditated decisions of a skilled medical administrator on medical matters, the medical profession feels that it has been offered an affront. This, however, is of the least importance. What matters most is that the unfortunate person about whom a recommendation has been made is the person to suffer. Medicine has been practised for thousands of years, affronts have been offered to its practitioners and indignities have been suffered by them, but the work of medical men goes on just the same. What they try to secure is the welfare of the individual and the promotion of health in the community. If they are thwarted by administrators ignorant of medical matters, good fellows though they may be in other directions, the community must be the loser. It is to be hoped that the medical profession will continue to try to drive this lesson

home to parliamentarians in charge of governmental departments throughout the whole Commonwealth.

The discussions on the *Pharmaceutical Benefits Act* showed that the free dispensing of what are known as life-saving drugs under the provisions of the Act is serving a useful purpose. Attention should be drawn to one or two important points. In the first place, the importance of the receipt by the Minister of technical advice by experts should be emphasized. A second point has to do with the therapeutic efficiency of drugs supplied as pharmaceutical benefits. It is very difficult to police the products of embryo or mushroom pharmaceutical manufacturing businesses. It is, however, of the greatest importance that this should be done. It is for the Minister for Health and his advisers in the Department of Health to devise some means for the testing of pharmaceutical efficiency, if not for the supervision of new pharmaceutical businesses, and possibly for the investigation of certain older concerns. When we discover that pharmaceutical houses of many years' standing and of known reputation, with all their equipment for manufacture and distribution, are able to sell a product only at a certain price, and then when we discover that some new concern, of comparatively new conception and birth, puts on the market what purports to be the same product at a fraction of the price asked by the older firms, we may be forgiven for asking whether anything is wrong. Another point to which attention should be directed has to do with the general value and adequacy of the *Pharmaceutical Benefits Act* as at present constituted. This is shown by reference to the *British Medical Journal* of March 3, 1951. A leading article in this journal is entitled "Paying for the N.H.S.". All students of national health service problems are advised to read it. The Minister of Health of Great Britain has reminded the country that the insurance contributions accounted for only £40,000,000 of the £400,000,000 which is now the annual bill for the national health service. Of the cost 90% is paid for out of taxation, and if the costs continue to rise (there is every reason to suppose that they will), taxpayers "will have progressively less choice in the spending of their money". The suggestion has been made that charges might have to be made throughout the service, and the *British Medical Journal* sees in this nothing to offend against the idea that there should be no financial obstacle between the patient and the treatment he needs. The article continues: "There is, for example, much to be said for the Australian arrangement whereby the essential and expensive drugs such as the antibiotics should be completely free of charge while the rest should be paid for." What is happening in Britain should thus make us realize that we seem to be on the right track. The experience of New Zealand would indeed seem to bear this out.

In regard to the discussions which took place on the pensioner medical service, it should be made clear that this service is already in being, and that many practitioners in each State have agreed to take part in it. It is true that dissatisfaction has been expressed at the remuneration which was proposed at the Federal Council meeting in May, 1950. Many practitioners are quite willing to give concessions to pensioners, but not to a government in charge of the welfare of pensioners. The

Minister's agreement that the rate of payment should be reviewed every six months opens the way for the new rates suggested at the recent meeting. At first sight there might seem to be some conflict between the arrangements for the pensioner medical service and the fact that contract medical service as such has practically ceased in every State, and that a fee-for-service system is to be the order of the day. In the discussions on medical service to members of friendly societies, the Federal Council made it quite clear that the profession reserved to itself the right to adopt concessional rates of payment for certain groups when these seemed necessary and desirable. It would be contrary to the tradition of the medical profession if this right was not retained.

There are three other subjects to which attention must be drawn. In the first place arrangements have been started for the holding of the eighth session of the Australasian Medical Congress (British Medical Association) at Melbourne in August, 1952. Sir John Newman Morris is to be president and Dr. C. H. Dickson general secretary. Further reference to this session of congress will be made at a later date. The second matter, which must be noted with satisfaction, is that the Federal Council is to seek expert advice and to study the administration of a national health service. In this regard emphasis should be laid on the statement of Dr. H. Leigh Cook that the interest of the State in national health is essentially political, but that it need not be party political. Finally, it is gratifying to note that the Federal Council has at length determined to set up a committee on medical education—something which it was originally urged to do by this journal in the issue of March 4, 1950 (page 305).

Current Comment.

FURTHER CONDEMNATION OF THE BEDPAN.

DISPARAGING REMARKS about the bedpan have been made in many places, including these columns, but these remarks have been based on the obvious psychological objections and on general impressions of physiological disadvantages. No exact physiological studies of the question have been available. However, an important contribution has now been made towards filling this gap in our knowledge, with interesting results. An investigation has been carried out by J. G. Benton, H. Brown and H. A. Rusk¹ to measure the energy expended by patients using the bedpan and the bedside commode respectively. This was based on the oxygen consumption (in excess of resting) as determined by means of a closed circuit respirometer. A total of 28 subjects was studied; 15 were ambulant patients with compensated cardiac disorders, and 13 were either normal or suffering from non-cardiac diseases. Each of the subjects carried out actions simulating the process of defecation as closely as possible, on both the bedpan and the commode, for at least two trials of each; conditions were standardized. Early in the course of the study it became apparent that in all patients of the non-cardiac as well as the cardiac group, the performance required a consistently greater oxygen consumption on the bedpan than on the commode. The final analysis revealed that there was no significant difference for each of the respective activities in the non-cardiac and cardiac groups, but energy expenditure in terms of oxygen consumption

¹ *The Journal of the American Medical Association*, December 23, 1950.

above resting levels was consistently higher with the bedpan than with the commode (50.7% for the cardiac group and 48.4% for the non-cardiac group). The difference in mean excess oxygen consumption for the use of a bedpan and a commode in all subjects was objectively and statistically highly significant. The patients using the bedpan were allowed to sit up, but from postural considerations it might be assumed that had the supine position been used with the bedpan the difference in energy cost would have been even greater between subjects on the bedpan and those on the bedside commode.

It must be recognized, as Benton, Brown and Rusk point out, that for certain patients—those who are unconscious, disorientated, very debilitated or afflicted with severe physical disabilities—the use of the bedpan is a matter of physical necessity. It is also true that the straining and movement associated with defecation under any circumstances can cause changes in blood pressure or rises in intrapleural and intraabdominal pressures sufficient to induce cardio-vascular accidents; the bedpan *per se* need not be blamed for all the untoward events that have accompanied its use. But from both a postural and an energy-conserving standpoint the strain necessary for defecation is lessened by the use of the commode. In a small series of three patients, Benton, Brown and Rusk found that the use of the bedpan with the legs swung over the side of the bed and the feet resting on a stool resulted in less oxygen consumption than the use of the bedpan in the sitting position in bed. For those who cannot even assume this position, adjustment of the bed and pillows should make possible in many cases a position to some extent nearer the customary position than that usually associated with the bedpan. It is certainly clear now that from both the physiological and the psychological points of view the use of the bedpan is indefensible in other than certain specified circumstances. The prejudice of hospital authorities against the commode is difficult to understand, but the evidence now available indicates that the bedpan is largely an objectionable and often dangerous anachronism. The half-humorous jibes of the past need to be replaced by deliberate opposition to its continued use unless absolutely necessary.

TRACHEOTOMY IN POLIOMYELITIS.

TRACHEOTOMY must in certain cases of poliomyelitis be considered life-saving. In view of this and in view of the importance of details in its use and in associated management of the patient, two recent articles will be of general interest.¹ One is from Sweden and the other from the United States. In Stockholm, according to Arne Sjöberg, the problem of bulbar poliomyelitis became acute in an almost frightening and dramatic way during the autumn of 1949, when severe cases of this form of the disease began to occur in large numbers. An investigation published in 1948 had revealed an extremely high mortality rate (86%) amongst patients throughout Sweden requiring respirator treatment, and the investigators considered that the causes of death were pareses of the respiratory muscles and circulatory collapse. Sjöberg shares the current American opinion that the majority of fatal cases in the early stages of infantile paralysis are, most probably, primarily due to suffocation—anoxia—and not to circulatory paresis. The operative treatment (tracheotomy and/or bronchoscopic suction) is directed towards overcoming this suffocation, and Sjöberg reports that, as a result of its use, 12 patients have been saved out of 14 treated at the Hospital for Infectious Diseases in Stockholm in the current outbreak, though all of them would previously have been regarded as being in a hopeless condition. From his experience Sjöberg divides the indications for operative treatment into five groups, based on the mechanism of suffocation. The first is peripheral respiratory paresis with retention of secretions. The

second is aspiration of saliva and vomitus in association with purely bulbar cranial nerve lesions, especially paralysis of the vagus. For these two groups bronchoscopic suction is particularly important. The third is laryngeal abductor paralysis combined with two-sided pharyngeal paresis. For these tracheotomy is life-saving. The respirator may be of use only when a tracheotomy has been performed, and if there is paresis of the respiratory muscles. The fourth is the group of spino-bulbar lesions combined with two-sided pharyngeal paresis, and to this group most of Sjöberg's cases have belonged. These patients, he points out, have a very typical picture of suffocation, and if their lives are to be saved they must be kept under constant observation and controlled carefully by trained observers. The suffocation picture in these cases is dominated by the angle, or "rope dent", symptom, which constitutes an alarm signal for the nursing staff. The patient runs the risk of being "hanged or strangled" at any minute by a contracture or tonus excess in his non-paralysed antagonistic muscles, which draw the hyoid bone backward and upward. If, in addition, a nuclear paresis of the accessory nerve sets in, the "rope dent" symptom is further accentuated and the patient's condition is aggravated, owing to contracture of the non-paralysed muscles which bend the head backward. The right combination of respirator treatment, tracheotomy and bronchoscopy is all-important, according to the stage of the disease. The last group is of those in which tracheotomy is performed prophylactically. Sjöberg states that the answer for the future to the question of when tracheotomy should be performed seems to be that it should be performed early and prophylactically in serious cases. With limited experience it is still difficult to determine the suitable cases, but that difficulty should be overcome. Other measures must not be neglected. Postural drainage with oxygen or "Carbogen" administration is absolutely necessary. In the first, sometimes the second, week fluid balance must be carefully controlled and the liquid administered only parenterally in isotonic or hypertonic form. Administration of dextran and blood transfusion help in the shock that may follow tracheotomy. The importance of the right use of the respirator needs no emphasis, but it must be appreciated that in all types of respiratory paresis, the respirator treatment may be directly harmful and can even hasten death by suffocation if bronchoscopic suction with or (in exceptional cases) without tracheotomy is not applied simultaneously.

In the American paper on the subject R. J. Strobel and N. Caulfield point out that the oto-laryngologist is constantly seeing patients with various respiratory problems and is consequently well able to recognize signs of impending or existing respiratory distress. He should therefore be consulted early concerning every patient with poliomyelitis who has respiratory paralysis or signs of bulbar involvement. Strobel and Caulfield state that therapeutic tracheotomy should be considered whenever any respirator patient shows signs of bulbar involvement or displays persistent cyanosis or struggling, and whenever any non-respirator patient is unable adequately to keep his airway free of secretions, as shown by the presence of moist râles, choking and cyanosis. Prophylactic tracheotomy should be considered whenever early and progressive bulbar signs are present and before the patient has difficulty, and whenever a "long siege" in the respirator seems probable, even though no bulbar signs are present. This paper records 10 cases in which tracheotomy was performed on patients with bulbar poliomyelitis. Five of the patients died, though in no case could the death be attributed to the operative procedure; possibly three of the lives could have been saved by earlier tracheotomy. In all cases of survival, the tracheotomy was probably life-saving. Strobel and Caulfield describe a number of technical details of tracheotomy associated with poliomyelitis. Their first-hand study should be of value to those who are less experienced in this now well-established and important procedure.

¹ Archives of Otolaryngology, September, 1950.

Abstracts from Medical Literature.

MEDICINE.

Hæmoptysis and the Diurnal Variation in the Vital Capacity.

E. DISSMANN (*Acta tuberculosea Scandinavica*, Fasciculi III-IV, 1950) has found that the vital capacity of tuberculous patients exhibits a rhythmic diurnal variation. The vital capacity is least, that is to say, the lungs contain most blood, as a rule between 6 p.m. and 9 p.m. and between 6 a.m. and 9 a.m. Hæmoptysis has been found to occur more frequently within these hours than at other times.

Tuberculosis following Immersion in Sewage-Polluted Water.

P. SÉNÉCAL (*Acta tuberculosea Scandinavica*, Fasciculi III-IV, 1950) reports two cases of primary pulmonary tuberculosis occurring in children who had fallen into water, known to be polluted with sewage, not far from Stockholm. The incubation period was forty-two days in one case and between forty-five and fifty-two days in the other.

Potassium in Clinical Disturbances of Body Water and Electrolytes.

DANIEL C. DARROW (*The New England Journal of Medicine*, June 29, 1950) reports that hyperkalemia causing symptoms is practically confined to patients with renal failure, advanced dehydration or shock. A high serum potassium level accompanied by a high intracellular potassium level occurs in adrenal insufficiency. The development is probably confined to advanced stages, when deficits of water are superimposed on deficiency of sodium. Although potassium is known to be unusually toxic to patients with adrenal insufficiency, the disturbances are not due simply to excess of potassium. Heart failure and other disturbances caused chiefly by hyperkalemia are seen in renal failure, severe dehydration and shock. Potassium intoxication can be produced by injudicious parenteral injections of potassium salts, but it is difficult, if not impossible, to produce potassium poisoning by oral administration except in patients with renal failure, shock or adrenal insufficiency. The symptoms of hyperkalemia are chiefly cardiac and are related to the elevation in concentration of potassium in plasma and not to the increase in intracellular potassium concentration of the heart. The following symptoms have been associated with elevation of the concentration of potassium in serum: listlessness and mental confusion; numbness and tingling of the extremities, with a sense of weakness and heaviness of the legs; cold, grey pallor; bradycardia and totally irregular cardiac rhythm; peripheral vascular collapse, poor heart sounds and low blood pressure; ascending flaccid paralysis. The diagnosis of hypokalemia and deficiency of potassium is made by recognition of the disturbances known to lead to deficits of potassium, by the determination of the concentration of potassium in the

serum, and by the electrocardiogram. The chief symptoms characteristic of potassium deficiency, such as paralysis of skeletal muscles, electrocardiographic changes, intestinal distension and paralytic ileus, are related to the low concentrations of potassium in the serum. Potassium chloride is usually the salt of choice, since chloride and potassium deficiencies are likely to be associated with each other, and because this salt is readily sterilized and may be given intravenously or subcutaneously as well as by mouth. Oral administration is relatively safe and, if possible, is the route of choice. The normal adult ingests about four grammes of potassium chloride per day. This amount can be given divided into two to four doses in twenty-four hours. Howard recommends a concentrated meat broth, an old-fashioned remedy, which has the advantage of containing large amounts of potassium together with other ions and cellular constituents. In the final summary the author states that changes in body water and electrolyte usually involve disturbances in body potassium as well as sodium, chloride and water. Acidosis may be explained by relative deficit of potassium or sodium or both. Alkalosis tends to produce deficit of potassium if renal adjustment is achieved. Deficit of potassium induces alkalosis if renal adjustment is achieved. Loss of potassium is likely to occur when the intake is low, during parenteral administration of fluids containing no potassium, in diarrhoea of various types, during post-operative gastric suction, after injection of desoxycorticosterone acetate, cortisone and ACTH, in some conditions associated with increased adrenocortical activity, and perhaps in starvation.

Physical Medicine and Invalidism.

F. A. HELLEBRANDT (*The Journal of the American Medical Association*, April 1, 1950) discusses physical medicine and rehabilitation in the prevention of chronic invalidism due to aging, acute illnesses, accidents or injuries. He states that the evils of bed rest and the benefits of early ambulation have been often praised in the last ten years. It has been suggested that early ambulation following surgery may be less prophylactic than was at first supposed. However, the authors point out the value in all illness of massage, passive movement and bed exercise as soon as possible, and the use of exercises as soon as the patient begins to walk. It is said that abnormal protein catabolism contributes to the debility following trauma and ill health, and that massage and passive movement have an immediate salutary effect on the negative nitrogen balance. Bed exercises and early ambulation are also of value in the prevention of respiratory distress and symptoms of cardiovascular inefficiency, such as palpitation, tachycardia, dyspnoea and vertigo.

Parkinsonism Treated with "Lysivane" and "Artane".

O. GARAI (*The Lancet*, February 24, 1951) has treated 70 patients suffering from parkinsonism, 51 receiving "Artane", 43 "Lysivane" and 24 both drugs at different times. Improvement was noted in approximately three-quarters of each group. The author states that both drugs control the

rigidity better than the tremor. Both reduce the number and duration of oculogyric crises in post-encephalitic parkinsonism. Higher dosage of "Artane" than that reported by other workers has been used with good effect and minimal side-effects. The results indicate that the action of "Artane" is often enhanced by amphetamine sulphate in post-encephalitic subjects. "Artane" is less likely to produce unpleasant side-effects than "Lysivane"; the author considers that for this reason it is likely to prove the drug of choice for most cases of parkinsonism.

Vitamin K and Hæmorrhagic Disease.

J. D. HAY, F. P. HUDSON AND T. S. RODGERS (*The Lancet*, February 24, 1951) administered vitamin K to 4602 pregnant women before delivery. There were 12,131 controls. Hæmorrhagic disease was observed in 11 of the newborn infants of the group treated with vitamin K (1 in 418) and in 23 of the controls (1 in 527). The authors conclude that vitamin K had no effect on the incidence of hæmorrhagic disease in the series studied.

Ulcerative Colitis.

W. J. GRACE, S. WOLF AND H. G. WOLFF (*The Journal of the American Medical Association*, April 8, 1950) discuss emotional effects on chronic ulcerative colitis. Four patients with fistulae were studied. The patients had prolapse of the colon through operation wounds. During periods of anger or resentment the colon was found to be red, engorged, hyperactive and covered with a thick tenacious mucus, which had a high concentration of lysozyme. Hæmorrhage and even ulceration were observed to occur in the colon when the patients suffered from anxiety, especially of a protracted nature. Increased rhythmic contractions or sustained contractions of the colon were also observed during periods of anxiety or emotional upset. This hypermotility led to increased fragility of the colonic mucosa. These effects were similar to those produced by intramuscular administration of methacholine chloride, with which ulcerative colitis had been produced in animals.

Carbon Monoxide Anoxia.

E. W. AMYES, J. W. RAY AND N. W. BROCKMAN (*The Journal of the American Medical Association*, April 8, 1950) report the effects of intravenous administration of procaine hydrochloride in treatment of carbon monoxide anoxia. They state that in the winter of 1948-1949 in Los Angeles, 32 cases of this kind occurred, and in the three years from 1947 to 1949, 109 persons died from carbon monoxide poisoning. In every case an open gas flame was burning in the room in which the patient was found. The authors state that the breathing of even low concentrations of carbon monoxide causes poisoning. Treatment consists of removal of the patient, artificial respiration, oxygen-carbon dioxide inhalation, warmth, and respiratory stimulants. Carboxyhaemoglobin usually disappears from the blood in twelve to twenty-four hours, yet symptoms may persist. The pathological changes are noted around blood vessels, especially in the basal ganglia, where bilateral softening often occurs. Intravenous injection of procaine hydro-

chloride, 500 milligrammes in 500 millilitres of 5% dextrose in water, was given to patients who did not respond to the usual treatments. Various mental effects, such as aphasia, catatonia and schizophrenia, were noted, and these were relieved by the intravenous procaine therapy. Patients suffering from chronic effects of some months' duration did not benefit.

Primary Tuberculosis in Children.

KURT HOLMDAHL (*Acta tuberculosea Scandinavica*, Supplementum XXII) states that the clinical picture and the early prognosis of primary tuberculous infection in children are already well known, but previous investigations of the late prognosis and especially the risk of development of post-primary pulmonary tuberculosis need to be supplemented. He has set out to throw light on the symptomatology and the prognosis, especially the late prognosis, of pulmonary tuberculosis and the factors of importance in the prognosis on the basis of an extensive series of cases of primary tuberculosis with *erythema nodosum* in children.

Horner's Syndrome.

NORMAN S. JAFFE (*Archives of Ophthalmology*, November, 1950) attempts to provide a system for localization of lesions causing Horner's syndrome. He states that the Horner syndrome consists of miosis which is maximum only immediately after the sympathetic nerve is divided, ptosis which is not as extensive as that seen with levator paralysis, and which also is not a constant feature, enophthalmos, ocular hypotony about which there is much controversy, anhidrosis (an absence of sweating on the ipsilateral side of the face), transitory rise in facial temperature, depigmentation of the iris, and alteration in secretion of tears. In Horner's syndrome due to a lesion in the thorax or neck or along the internal carotid artery, the pupil does not dilate in response to cocaine. However, cocaine does dilate the pupil if the lesion is central. Adrenaline causes a strong dilatation of the pupil if the lesion is of the third neuron. Homatropine dilates the affected pupil poorly. The miosis of Horner's syndrome differs from irritative miosis in that in Horner's syndrome the pupil reacts to light. The author enumerates the causes of Horner's syndrome at various levels, that is, at the first neuron, in which the syndrome is incomplete, at the second neuron and at the third neuron. He presents four cases in which Horner's syndrome was a feature.

Magnesium Intoxication.

ALEXANDER R. STEVENS and HAROLD G. WOLFF (*Archives of Neurology and Psychiatry*, May, 1950) discuss the toxic effect of magnesium. Their work followed the death of a girl given magnesium sulphate rectally for the relief of convulsions due to a cerebral tumour. Patients were given varying doses of magnesium sulphate rectally and the clinical effects were noted. The authors state that the normal blood serum level of magnesium is between 1.5 and 2.5 milligrammes per 100 millilitres. If the level is four milligrammes per 100 millilitres a sensation of warm skin and dry mouth develops. If a level of seven milligrammes per 100 millilitres is reached

drowsiness follows, and at a level of 20.1 milligrammes per 100 millilitres respiratory arrest and death occur. A level of four milligrammes per 100 millilitres was reached by giving 25 grammes by mouth, and 94 grammes given *per rectum* produced a blood level of seven milligrammes per 100 millilitres. The patient who died had received 189 grammes. The authors suggest that magnesium sulphate may be absorbed rapidly and that in rectal administration amounts of less than 94 grammes over three-hour periods should be given. If toxic symptoms occur, such as flushed skin with a feeling of warmth, dry mouth and drowsiness, calcium should be administered intravenously. The toxic effect of magnesium is increased with impaired renal function.

Pleocytosis and Meningeal Signs in Uremia.

M. J. MADONICK, K. BERK AND I. SCHIFFER (*Archives of Neurology and Psychiatry*, September, 1950) describe the cell count in the cerebro-spinal fluid in 62 cases of uremia. In 16 cases a cell count of ten or more per cubic millimetre was found; the highest count was 250 lymphocytes per cubic millimetre. The cause for the presence of the cells is not apparent, nor the cause for the variability in their number. There is no relationship to the amount of urea in the cerebro-spinal fluid. In a third of these cases clinical signs of meningeal irritation were present. No relationship could be found between this finding and the cell count.

Amoebiasis.

J. D. HUGHES (*The Journal of the American Medical Association*, April 8, 1950) reports 38 cases of amoebiasis in which treatment was carried out with aureomycin. He states that the patients, who were in Tennessee, had persistent amoebiasis, which had been ineffectually treated with carbarsone, "Diodoquin" and "Vioform", but curiously enough few had been treated with emetine. It is said that these 38 patients were difficult to cure with the drugs employed. Each patient was treated on an ambulatory basis, with 28 capsules of 0.25 gramme each, over four to seven days. Antacids, alkalis, belladonna and barbiturates were used to control nausea, and paregoric was given for intestinal colic following aureomycin. Of the 38 patients, 27 were relieved of symptoms and had five negative results from stool examinations. The author suggests the use of larger doses of aureomycin.

Myasthenia Gravis.

L. M. EATON and O. T. CLAGETT (*The Journal of the American Medical Association*, April 1, 1950) discuss the treatment of myasthenia gravis by thymectomy. They state that remissions occur in myasthenia gravis, hence there is need for caution in assessing results of treatment. Seventy-two patients had an operation to remove the thymus or a thymic tumour; 142 patients were treated without operation. Complete remissions of the disease occurred in an equal number of operated and non-operated patients, but greater improvement was noted in the operated group. By excluding the operated patients who died soon after operation (six), and four others who had only minor operations on the thymus, the authors have 62 surgically

treated patients for comparison. They report that a truly gratifying result occurred in 35% of operated patients, as against 28% in the non-operated group. They conclude that thymectomy does not influence the cause of myasthenia beneficially, and that operation on the thymus should not be recommended unless (i) a thymic tumour can be demonstrated radiologically, (ii) the risks of the operation are not excessive, and (iii) radiological and clinical evidence indicates that the condition is operable.

Bilateral Adrenalectomy in Hypertension.

D. M. GREEN *et alii* (*The Journal of the American Medical Association*, October 7, 1950) describe bilateral adrenalectomy in malignant hypertension and diabetes. They state that adrenocortical involvement is present in hypertension. Pituitary influences on blood pressure are related to adrenocortical mediation or lack of it. Renal hypertension requires corticosteroid participation. The adrenal cortex seems to be involved also in the sustained phase of adreno-medullary hypertension. In pheochromocytoma the disease progresses into a chronic hypertensive stage. Desoxycorticosterone acetate, primarily a synthetic salt-retaining steroid, induces hypertension and associated cardiac and renal lesions in the salt-fed rat and also the rat receiving a normal diet. Adrenal cortex involvement is also suspected on account of the occurrence of hyperglycemia and glycosuria in a majority of severely hypertensive patients subjected to a four-hour test. Hypertension may be induced in an adrenalectomized animal or in human Addison's disease by use of desoxycorticosterone. The evidence of abnormal adrenal cortex function in prolonged human hypertension suggested a possible cure by removal of the adrenal glands. Four patients had unilateral adrenalectomy. One died of the operation, one recovered and died of encephalopathy, and two lived. One patient had a bilateral adrenalectomy for hypertension and diabetes with apparent ultimate benefit.

Aureomycin and Primary Atypical Pneumonia.

E. B. SCHOENBACH *et alii* (*The New England Journal of Medicine*, November 23, 1950) have studied 22 consecutive patients treated in hospital for primary atypical pneumonia in 1946 and 1947, and 33 consecutive similar patients treated with aureomycin only in 1948 and 1949. The groups were comparable in sex, age, duration of disease before admission to hospital, temperature on admission, degree of pulmonary involvement and proportion developing cold agglutinins. The average duration of fever during the hospital period was 6.4 ± 0.85 days for the group treated in 1946-1947 and 3.1 ± 0.07 days for the aureomycin-treated group. The average duration of fever in the latter group was 1.8 ± 0.23 days after the beginning of aureomycin therapy. The total duration of the febrile period was also materially shortened in the aureomycin-treated group, with an average of 7.8 ± 0.89 days from onset of illness to defervescence; patients not receiving aureomycin were febrile for an average period of 13.0 ± 0.94 days. No significant toxic reactions to the aureomycin therapy were noted.

British Medical Association News.

MEETING OF THE FEDERAL COUNCIL.

A MEETING of the Federal Council of the British Medical Association in Australia was held at the Medical Society Hall, Albert Street, East Melbourne, on February 26, 27 and 28, 1951. SIR VICTOR HURLEY, K.B.E., C.B., C.M.G., the President, in the chair.

Representatives.

The following representatives of the Branches were present:

New South Wales: Dr. A. J. Collins, D.S.O., M.C., Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. J. Murray, O.B.E.

Queensland: Dr. A. E. Lee, Dr. H. W. Horn.

South Australia: Dr. L. R. Mallen, Dr. C. O. F. Rieger.

Tasmania: Dr. T. Giblin, Dr. J. B. G. Muir.

Victoria: Sir Victor Hurley, K.B.E., C.B., C.M.G., Dr. H. C. Colville, Dr. C. Byrne.

Western Australia: Dr. F. W. Carter, Dr. Leigh Cook.

Minutes.

The minutes of the meeting of the Federal Council of May 26, 27, 28, 30 and 31, 1950, and of the special meeting of September 23 and 24, 1950, which had been circulated amongst members, were taken as read and signed as correct.

The Retirement of Dr. J. L. Grove.

The President drew attention to the retirement of Dr. J. L. Grove, one of the representatives from Tasmania. The Federal Council decided to place on record its appreciation of the valuable services rendered to the Council and to the profession in Australia by Dr. J. L. Grove while he was a member of the Federal Council from January 1, 1948, to December 31, 1950.

Election of Office-Bearers.

Only one nomination for the office of president for the ensuing twelve months had been received, that of Dr. A. J. Collins, who was declared elected.

Only one nomination for the position of vice-president had been received, that of Dr. H. C. Colville, who was declared elected. The President explained that Dr. F. W. Carter had been nominated for the position of vice-president, but he had withdrawn his acceptance of the nomination.

Only one nomination, that of Dr. W. F. Simmons, was received for the office of honorary treasurer, and Dr. Simmons was declared elected.

At this stage in the meeting Sir Victor Hurley vacated the chair in favour of Dr. A. J. Collins. Dr. Collins thanked the members for his election.

Death of Dr. John Hubback Anderson.

Sir Victor Hurley referred to the recent death of Dr. John Hubback Anderson and to the high regard in which he was held by members of the medical profession in all parts of Australia. He was supported by Dr. A. J. Collins, the President, who referred particularly to Dr. Anderson's work during the two world wars. The following minute was adopted by the Federal Council:

That the Federal Council place on record its sincere appreciation of the valuable services rendered to the British Medical Association in Australia by Dr. J. H. Anderson as representative of the Branches on the Council of the Parent Body, and expresses its deep regret at his death, and that the sympathy of the Federal Council be extended to his son and daughter in their great loss.

Annual Report of the Federal Council.

The annual report of the Federal Council for the year ended June 30, 1950, was received and adopted.

The Secretariat.

The President referred to the resignation of Dr. J. H. Priestley, who had held the office of assistant secretary, and to the termination of his services in September, 1950.

The Federal Council resolved that its thanks should be extended to Dr. Priestley for the services which he had rendered during his term of office.

The Federal Council considered the appointment of an assistant general secretary, and it resolved that the President, the Vice-President and the Honorary Treasurer, in consultation with the General Secretary, should be empowered to appoint an assistant general secretary at a suitable salary.

The Henry Simpson Newland Prize Fund.

Dr. W. F. Simmons, the Honorary Treasurer, reported on the state of the Henry Simpson Newland Prize Fund. It was resolved that the fund should be kept open for contributions until June 30, 1952, and that the Branches should be asked to make a further appeal to members for contributions to the fund.

Finance.

The financial statement and balance sheet of the Federal Council as at December 31, 1950, were received and adopted.

The contributions of the Branches for 1951 were noted, and Dr. W. F. Simmons gave an estimate of the probable expenses up to December 31, 1951. He thought that possibly three meetings of the Council might be held.

Dr. Simmons referred to the Federal Independence Fund. It was resolved that the Branch Councils should be asked to forward to the Honorary Treasurer of the Federal Council any moneys standing to the credit of the Federal Independence Fund. Reference was made to the original provision that any unused surplus of the fund should be returned *pro rata* to the contributors. This provision was discussed, and it was pointed out by several members that a position had not yet been reached at which the return distribution could be made with safety. It was resolved that the money standing to the credit of the Federal Independence Fund should be retained until the first meeting in 1952, when the matter would be further considered.

Medical Officers' Relief Fund (Federal).

On behalf of the trustees of the Medical Officers' Relief Fund (Federal), Dr. W. F. Simmons presented an interim report for the six months ended December 31, 1950. Dr. Simmons pointed out that four loans outstanding amounted to just over £1302. During the year a further claim for assistance had been received. The report was adopted.

The Federal Medical War Relief Fund.

On behalf of trustees of the Federal Medical War Relief Fund, Dr. W. F. Simmons presented a report for the half-year ended December 31, 1950. During the half-year 17 benefactions had been paid—four from New South Wales, seven from Queensland, three from Victoria and three from South Australia. The report was adopted.

Honours.

The General Secretary reported that honours had been conferred by His Majesty the King on the following: Sir Neil Hamilton Fairley, Sir Wilberforce S. Newton, Sir Frank Macfarlane Burnet, Dr. W. K. McIntyre, Dr. C. Craig, Dr. Lucy M. Bryce, Dr. H. McI. Birch, Dr. H. T. Chapman, Dr. J. A. James, Dr. A. R. S. Vickers. The congratulations of the Federal Council had been offered to each recipient.

Inquiries by Overseas Practitioners about Practice in Australia.

The General Secretary reported that he had received inquiries from a number of overseas practitioners, whom he named, regarding the possibilities of practice in Australia. He had replied in each instance, and had referred the inquiring practitioner to the State Medical Boards.

Congress on Venereal Diseases.

The General Secretary reported that he had received from the Secretary of the Prime Minister's Department, Canberra, a copy of a dispatch from the Commonwealth Relations Office, London, relating to a congress on venereal disease to be held at Zurich, Switzerland, on July 29 to August 1, 1950. The information had been sent on to the Branches.

Pakistan Medical Conference.

The General Secretary reported that he had received from the Department of External Affairs a copy of a letter received by the High Commissioner in Karachi. The letter was from Dr. Munawar Ali, forwarding an invitation to

the medical practitioners in Australia to attend the first All-Pakistan Medical Conference, to be held at Karachi in February, 1951. The General Secretary said that he had sent the letter on to the Branches, and that he had written to Dr. Munawar Ali conveying the greetings and best wishes of the Federal Council for the holding of a successful conference.

The Australian National Antarctic Research Expedition.

The General Secretary had received a letter from Mr. T. G. Heath, of the Department of External Affairs, requesting further help in the obtaining of medical officers for the expedition to Heard and Macquarie Islands.

The Sims Commonwealth Travelling Professor.

The General Secretary said that he had received a letter from The Royal Australasian College of Physicians, setting out the itinerary of Professor D. M. Dunlop, Sims Commonwealth Travelling Professor for 1951.

Services Canteens Trust Fund.

The General Secretary reported that he had received from the general secretary of the Services Canteens Trust Fund a letter appealing to the members of the medical profession to enable the trustees of the Services Canteens Trust Fund to make the best use of the fund for the benefit of men and women who served in the 1939-1945 war, and who needed financial assistance. The secretary asked that more use might be made of public hospital beds than of beds in private hospitals. The General Secretary said that the letter had been forwarded to the Editor of THE MEDICAL JOURNAL OF AUSTRALIA and published by him (see THE MEDICAL JOURNAL OF AUSTRALIA, December 9, 1950, page 876). He had suggested to the secretary of the fund that, having regard to its stated objects, the fund be not used for the purpose of paying the costs of hospitalization. The General Secretary's action was approved.

Philippine Medical Association.

The General Secretary reported that he had received from Dr. Rodolfo Gonzalez, president of the forty-fourth annual convention of the Philippine Medical Association to be held at Manila on May 1 to 5, 1951, an invitation to the Federal Council to send delegates to the convention.

International Union Against Venereal Disease.

The General Secretary reported that he had received a letter from the Director-General of Health, Canberra, advising that the General Assembly of the International Union Against Venereal Disease was to be held at Paris on May 21 to 25, 1951.

International Congress of Anaesthesiology.

The General Secretary said that he had received from the Director-General of Health, Canberra, an announcement that the International Congress of Anaesthesiology was to be held at the Salpêtrière Hospital, Paris, on September 20 to 22, 1951.

Australasian Medical Congress (British Medical Association).

Seventh Session.

The General Secretary announced that he had received from the honorary general secretary of congress a copy of the minutes of the executive committee of congress.

The General Secretary laid on the table a report from the honorary general secretary of congress on the general management and finances of the seventh session.

The General Secretary had received from Dr. H. W. Horn, honorary treasurer of the seventh session, a cheque for £1306 2s. 6d., being the surplus from congress funds. It was explained that this amount included £500 which had been advanced to the executive committee of the seventh session by the Federal Council. The executive committee of congress also forwarded the sum of £234 18s. 3d., which represented profit on the congress dinner. The Federal Council at its previous meeting had been advised of this profit, and had resolved to adopt the suggestion of the executive committee that the money should be used to establish an entertainment fund, for the purpose of entertaining visitors at future sessions of congress. The Federal Council resolved that the Queensland Branch should be asked to convey to the president, honorary secretary,

honorary treasurer and executive committee of the seventh session the congratulations of the Federal Council on the successful organization of the congress.

The Federal Council had before it a recommendation from the Section of Ophthalmology in regard to the use of a standard form for the certification of blindness. The section held that this would be useful for the purposes of recording blindness in the future. The form should contain certain detailed information, and should be completed by an oculist and filed separately. The Federal Council resolved to discuss with the Department of Pensions at Canberra the use of a standard form for the certification of the blind.

The Federal Council received from the Section of Medicine a recommendation that at future congresses a section of thoracic diseases should be formed. The Federal Council resolved that the establishment of such a section was not desirable, and did not approve of the recommendation.

The Federal Council received from the Section of Naval, Military and Air Force Medicine a recommendation that consideration should be given to the complete standardization of all medical documents throughout the medical services of the defence forces. The Federal Council resolved to adopt the recommendation, with a proviso that standardization should be carried out "where practicable".

Eighth Session.

The General Secretary reported that he had received from Sir John Newman Morris a letter thanking the Federal Council for having approved of his nomination by the Victorian Branch as president of the eighth session.

The General Secretary reported that the General Committee of Congress had held its inaugural meeting on Wednesday, January 17, 1951, at Melbourne. He and the Editor of THE MEDICAL JOURNAL OF AUSTRALIA had attended.

A letter was received from Dr. J. Bruce Hamilton, President of the Ophthalmological Society of Australia (British Medical Association), suggesting that a memorial oration in honour of the members of the medical profession who lost their lives while serving with the Empire forces in the wars of 1914-1918 and 1939-1945 should be established. It was resolved that Dr. Hamilton's letter should be sent to the executive committee of the eighth session for its consideration.

A sum of £500 was granted to the executive committee of the eighth session for preliminary expenses.

The General Secretary reported that he had had some correspondence with the Royal Australasian College of Surgeons, The Royal Australasian College of Physicians, the College of Radiologists (Aust. and N.Z.), the Australian Orthopaedic Association, the Australian Association of Psychiatrists, and the Urological Society of Australasia in regard to the dates of congresses. It was hoped that the dates of medical gatherings in different parts of the Commonwealth might be so arranged that there would be no interference with the attendance of members of the Branches at Australasian medical congresses. In every instance the body concerned had replied that it was anxious to avoid any clashing of dates. The General Secretary had pointed out to these bodies that after 1952 the Australasian medical congresses would be held only every three years.

A letter was received from the Repatriation Department Medical Officers' Association requesting that the regulations of congress be amended so as to include as a vice-president the principal medical officer of the Repatriation Department. The Federal Council decided not to approve of the request.

A letter was received from the New South Wales Branch, forwarding a letter from the Orthopaedic Group of that Branch, requesting that orthopaedics and physical medicine should not be grouped together in future congresses. It was resolved to forward to the executive committee of the eighth session the New South Wales letter, with a recommendation that the request be not approved.

Australasian Medical Publishing Company, Limited.

The General Secretary said that he had received from the secretary of the Australasian Medical Publishing Company, Limited, a notice of the thirty-seventh ordinary meeting of the company, together with the directors' report and financial statement. He had also received a notice of a meeting of directors, to be held at Melbourne on February 26, 1951.

The Federal Council resolved that the congratulations of the Federal Council should be extended to the Editor of THE MEDICAL JOURNAL OF AUSTRALIA on the excellence of the Commonwealth Jubilee Number of the journal.

Publicity.

It was resolved to reappoint as members of the Publicity Committee Dr. A. J. Collins, Dr. W. F. Simmons, Dr. H. R. R. Grieve, Dr. A. E. Lee, Dr. L. R. Mallen and Dr. C. H. Dickson.

Pharmaceutical Benefits Act, 1947-1949.

At its previous meeting the Federal Council discussed the regulations under the *Pharmaceutical Benefits Act*, 1947-1949. The General Secretary reported that after that meeting he had written to the Director-General of Health, informing him of the Federal Council's recommendations. These were five in number: (i) That a Commonwealth Government authority, either the Minister or the Director-General of Health, should indicate to the medical profession and the public the essential drugs that were in short supply. (ii) That an expert committee on the federal level should determine and inform the medical profession for which diseases these drugs in short supply might be justifiably used. (iii) That a committee be appointed in each State to control the distribution of aureomycin, "Chloromycetin" and streptomycin and other drugs declared to be in short supply. (iv) That the expert federal committee should give consideration to the suggestion that when practicable in-vitro sensitivity tests should be conducted in each case before drugs declared to be in short supply were prescribed. Further, that pending the appointment of the committee members of the medical profession should be circularized and be urged to use discretion in the prescribing of drugs in short supply. A reply had been received from the Minister stating that he proposed to introduce a regulation giving authority to set up a committee in each State to control the distribution of aureomycin, "Chloromycetin", streptomycin and dihydrostreptomycin, and any other drugs which might from time to time be declared to be in short supply. The Minister stated also that he had written to Dr. A. J. Collins, asking him to arrange for the special advisory committee on life-saving and essential drugs to prepare a list of diseases for which these drugs in short supply might justifiably be used. The Minister also stated that it would be appreciated if the State Branches of the Association were to nominate four or five members in each State to act as the advisory body in their particular State for the control of these drugs. The General Secretary said that each Branch had appointed an advisory committee of five members as requested by the Minister. In the discussion reference was made to a letter received in Western Australia from the Deputy Director-General of Health with regard to the prescribing and dispensing of pharmaceutical benefit prescriptions containing aureomycin, "Chloromycetin", streptomycin or dihydrostreptomycin. In this letter it was stated in terms of Regulation 14 as amended that before prescribing any item covered by the regulation in question, a medical practitioner had to obtain from the Director-General or his deputy an authority to prescribe the drug. With such authority would be given an approval number, which had to be marked on the prescription form. A chemist might not dispense a pharmaceutical benefit prescription for any of these drugs unless it was endorsed with the approval number by the medical practitioner. The Western Australian Branch, it was stated, had chosen four of its members to act on a committee as suggested by the Minister, and these members had been asked whether they would agree to act. They had consented, but so far nothing further had been heard of the committee. Dr. T. Giblin said that in Tasmania they had received the same kind of letter as had been received in Western Australia. In Hobart they had had to apply to the Chief Pharmacist. Dr. H. W. Horn said that in Queensland they had been given to understand that the drugs in question were not now in short supply. Dr. F. W. Carter said that at the Repatriation Hospital in Hollywood, Western Australia, there were no restrictions in regard to the use of the drugs. Reference was also made to what was regarded by the Victorian Branch as an unreasonably narrow interpretation of the regulations. Circulars had been issued to pharmacists, stating that not more than two pharmaceutical benefits could be prescribed on any one form even though the prescriptions might be for different strengths of a particular benefit, for example, pertussis vaccine. The Queensland Branch also referred to the provision that not more than one prescription for the same substance could be prescribed for the one person on one day. The Queensland Branch thought that this would operate most harshly in certain cases. The Federal Council resolved to communicate with the Minister on the matter. It was resolved that the General Secretary should ask the Minister whether any drugs were in short supply, and whether any regulation concerning restricted drugs applied at the present time. It was resolved that further information should be sought from the Minister on

the restrictions to prescribing mentioned in the letter from the Deputy Director-General of Health in Western Australia. It was also resolved that the attention of the Minister should be directed to Regulation 12, that referred to by the Victorian Branch, regarding the restriction of two pharmaceutical benefits to one prescription form.

A letter was received from the Western Australian Branch protesting against the inclusion of certain highly compounded medicines, whose inclusion in the official list of benefits had not been approved by the Pharmaceutical Benefits Advisory Committee. The General Secretary said that he had received the latest list from the Minister, and that the drugs mentioned in the Western Australian Branch letter were not included in it. Dr. Carter said that he thought the status of the committee should be defined by the Minister. With this view Dr. H. C. Colville was in agreement. After further discussion it was resolved that the Minister for Health should be asked to define the status of the Pharmaceutical Benefits Advisory Committee.

At the previous meeting of the Federal Council reference was made to the requirement that the words "pharmaceutical benefit" should be written on the doctor's prescription. The question was raised whether the writing of these words on the prescription form made it a government form. The matter had been referred to the Federal Council's legal advisers. In the opinion received from the Federal Council's solicitors it was stated that a doctor's own prescription form on which were written the words "pharmaceutical benefit" could not be regarded as a government form. The addition of the words to the doctor's prescription form in the opinion of the solicitors did not do anything more than make the doctor's own prescription form acceptable for the purpose of entitling the person, in respect of whom the prescription was written, to receive a pharmaceutical benefit under the Act.

In regard to drugs in short supply, the Federal Council at the instance of the Western Australian Branch discussed the necessity for the introduction of a twenty-four-hour service by the Department of Health, in order that patients might be able to obtain benefits. It was resolved that this would be discussed with the Minister.

At the instance of Dr. W. F. Simmons the Federal Council discussed the possible constitution of a Therapeutic Trials Committee. It was pointed out that many new manufacturing firms were making their appearance. Some of these might be described as backyard manufacturers, and the question naturally arose whether their facilities were adequate. Some of the preparations put on the market by these people were sold at a remarkably cheap rate, and it did not seem reasonable to suppose that they were as pure or as efficacious as those produced by the older and long-established manufacturing houses. When a patient took to his pharmacist a prescription containing drugs to be dispensed under the provisions of the *Pharmaceutical Benefits Act*, the pharmacist was compelled to dispense the cheapest form of the drug. That was all he was paid for, unless the prescriber named the preparation of some particular firm. A Therapeutics Trials Committee would determine whether the products were what they were supposed to be, and they would be therapeutically tested. Dr. F. W. Carter said that there was a standard of purity for drugs, and that was the standard laid down by the British Pharmacopoeia. The purity of drugs was a matter for the States. Dr. Carter thought that it would be necessary to accept State assurance, because the machinery required for a Therapeutic Trials Committee would be great. The financial cost also would be heavy. Dr. A. J. Collins agreed that a Therapeutic Trials Committee was beyond the powers of Australia. He thought that the department should be asked what steps were taken to check the claims made by new firms, particularly in regard to purity and the standard strength of preparations. It was resolved, on the motion of Dr. F. W. Carter, that the Federal Council should approach the Minister for Health and ask that steps be taken to ascertain the standard of purity of drugs for which application was made for inclusion in the list of drugs under the *Pharmaceutical Benefits Act* by drug firms hitherto unknown.

The General Secretary reported that the Federal Council had received an offer from the Commonwealth Government of a certain sum of money in settlement of costs in the recent High Court action between the Federal Council and the Commonwealth Government in regard to the *Pharmaceutical Benefits Act*. He had sent to each member of the Federal Council a copy of a letter from the Federal Council's solicitors dealing with the matter. The view of all members was that the offer should be accepted, and he had accordingly instructed the Council's solicitors to accept the offer.

Medical Planning.

National Health Service.

The Federal Council discussed a pensioner medical service. The General Secretary referred to a letter which he had sent to the Branches in November, 1950, and to the items discussed in that letter—the scope of service, the rates of pay, mileage, a review of payment, an entitlement card to be held by the patient, and the definition of a pensioner. Reference was also made to the notification by practitioners of their willingness to take part in the pensioner medical service. The responsibility of the members of the Branches towards non-members of the Association was also mentioned. It was resolved that the Branches should be informed that they should continue to ascertain and to notify to the General Secretary of the Federal Council the names of members of the Association who from time to time indicated their willingness to undertake service under the pensioner medical service. The Branches were also to be informed that the Federal Council thought it was unnecessary for them to undertake any similar responsibility in respect of non-members of the Association. In regard to the rate of payment, the Federal Council resolved that, in view of the increases which had taken place in the basic wage since May 26, 1950, the rates of payment of medical practitioners for attendance on pensioners under the pensioner medical service, of which the Minister for Health had been informed in May, 1950, should now be adjusted. The Federal Council also resolved to inform the Minister that, as from March 1, 1951, the rates of payment should be 7s. 6d. for consultation and 9s. 6d. for domiciliary visits. In view of the Minister's agreement that the rate of payment should be reviewed every six months, the Federal Council decided to ask that this adjustment should be made automatically on June 30 and December 31 of each year. The question of mileage was discussed. In a resolution on the subject the Federal Council expressed the opinion that a visit to a pensioner involving mileage was of necessity a special call, and that mileage should be paid from the commencement of the pensioner medical service on the basis previously submitted to the Minister for Health. Reference was made to the elaborate nature of some of the forms with which practitioners had to deal, and it was resolved that the views of the Branches in regard to the simplification of voucher forms in the pensioner medical service should be ascertained, and that when this had been done the executive officers of the Federal Council should be authorized to communicate with the Minister in regard to the matter. In regard to the pensioner medical service, Dr. Charles Byrne asked whether the prescriptions of non-participating doctors would be recognized, and he was told that they would.

The Federal Council discussed pharmaceutical services in connexion with the pensioner medical service. The General Secretary referred to a conference which had taken place in October, 1950, between the Minister for Health, Federal representatives of the Federated Pharmaceutical Service Guild of Australia and representatives of the Federal Council. At this conference the Minister had said that he wished to provide additional pharmaceutical benefits to pensioners, and that he had in mind limiting the benefits to products which could be compounded of any of the drugs within the British Pharmacopoeia or the British Pharmaceutical Codex, and that in order to ease administrative difficulties of staffing and accommodation it was necessary that the costing of prescriptions should be made as simple as possible. In the discussion which followed, it was made clear by the Federal Council's representatives that there should be no limitation of prescribing to any formulary or list of drugs, and that the doctor should be free to prescribe in a mixture, ointment and so on any drug contained in the British Pharmacopoeia or the British Pharmaceutical Codex. It was agreed that the department's difficulties in regard to costing would be to some extent eased if doctors would use whenever possible prescriptions contained in the pharmacopoeias of the larger Australian hospitals or in the Australian Pharmaceutical Formulary and so on. The General Secretary presented the Federal Council with a short and tentative formulary which had been drafted after consultation with members of the medical and pharmaceutical professions. In view of the assurance of the Minister that medical practitioners would have unrestricted right of prescribing in the working of the pensioner medical service, the Federal Council resolved that for the smooth working of the pensioner medical service it approved of the list of prescriptions and formulae which had been drawn up for the assistance of medical practitioners in prescribing for their patients.

At its meeting in September, 1950, the Federal Council discussed the form of administration of a national health service. It had before it the recommendations of the New South Wales Branch and also a scheme set out by the Western Australian Branch (see THE MEDICAL JOURNAL OF AUSTRALIA, November 4, 1950, page 702). At that meeting the Federal Council resolved that legal advice should be sought regarding the drafting of the constitution of a corporate body of control of a national health service with a minimum of political control. The Federal Council again considered the question of administration. The General Secretary read an extract from a legal opinion about the control of the British Broadcasting Corporation. He pointed out that control was eventually in the hands of the Postmaster-General. The Commonwealth Scientific and Industrial Research Organization also had its own controlling body, but eventually it came under Ministerial control, and the Public Service Board selected the officers. The Federal Council also had before it a memorandum on the administration of a national health service by Dr. H. Leigh Cook. In this document Dr. Cook stated that any suggestion that had as its aim the removing of the field of national health from the realm of party politics was worthy of consideration. If State interest was essentially political, it need not be party political. Dr. Cook quoted the opinion of Professor F. A. Bland that the interposition of an all-party committee between a commission or corporation and the party in power was not only practicable but desirable. The people of Australia were, in Dr. Cook's opinion, sick and tired of national health being regarded as a political football. The subject bristled with difficulties, and Dr. Cook thought that the Federal Council should decide whether (a) to appoint a committee of the Federal Council to seek expert advice on the question and submit a report to the next meeting, or (b) to urge Sir Earle Page to set up a representative committee immediately to investigate the whole problem of administration. The Federal Council resolved on the motion of Dr. T. Giblin, seconded by Dr. H. R. R. Grieve, to appoint a committee to seek expert advice on the question of administration of a national health service and to report to the next meeting of the Federal Council. It resolved that the President and the General Secretary should be members of the committee.

Acoustic Laboratory.

The Federal Council had before it a letter from the South Australian Branch protesting against the policy of the Acoustic Laboratory of providing treatment for deaf persons, and of making appointments to existing staff without the vacancies having been advertised. This letter had been referred to the Branches. The New South Wales Branch supported the South Australian Branch in its view, and the Victorian Branch expressed the opinion that appointments to the laboratory should be advertised in the usual way. The secretary pointed out that the laboratory was one of the activities of the Commonwealth Department of Health, and was managed in New South Wales by Mr. N. E. Murray, who had done a great deal of useful work in the recent war. Mr. Murray had explained that children were examined in the Department of Education in New South Wales, and that when medical officers of the department discovered an abnormality the children were referred to an ear, nose and throat surgeon. Both in public hospitals and in repatriation hospitals the services of ear, nose and throat specialists were also used. Mr. Murray said that he always required a patient to be examined by an ear, nose and throat specialist. Dr. C. O. F. Rieger said that in Adelaide patients were referred to the laboratory from the services. Dr. H. Leigh Cook said that in Western Australia the laboratory was in charge of a psychologist, and sometimes aid was given without an ear, nose and throat surgeon.

Federal Pharmaceutico-Medical Liaison Committee.

The Federal Council had before it a letter from the South Australian Branch regarding the activities of the Pharmaceutico-Medical Liaison Committee, which had been set up in that State. At a meeting of the committee the desirability of standardizing packaging of pharmaceutical preparations had been discussed, and the committee had decided that the question should be submitted to the Federal bodies of the two organizations concerned for consideration as to the best method of overcoming the difficulties that had arisen in connexion with the packing of various preparations. When a doctor wrote a prescription for a certain brand of preparation, he was often unaware that this might involve the opening of two different boxes of the drug in order to dispense the quantity desired, whereas, if all packages were standardized to contain a generally accepted

dosage, it would overcome the difficulty associated with broken boxes, and ensure that the patient obtained a completely fresh supply of the drug which his doctor had ordered, and at a lesser cost.

Another matter discussed had been the setting up of a committee to revise the British Pharmacopoeia from the Australian point of view. It had been understood that a request had been made to the Victorian Department of Health for suggested alterations and additions to the British Pharmacopoeia, and in view of the different climatic and social conditions throughout the Commonwealth of Australia, it was considered that any suggestions with regard to the British Pharmacopoeia would come better from a federal committee. A third matter considered was that of ethical preparations, and it had been decided to suggest to the federal body that an approach should be made to the government bodies concerned, asking that, on any ethical preparation of a British Pharmacopoeial drug, the name of the drug should be printed on the label in a size not smaller than the size of the name of the ethical preparation. After discussion it was resolved that the General Secretary should request Branch Councils to refer the matters contained in the letter of the South Australian Branch to their State medical pharmaceutical liaison committees for an opinion, and that such opinion should be forwarded to the Federal Council.

Control of the Use of Cortisone.

The Federal Council had before it a letter from the Editor of THE MEDICAL JOURNAL OF AUSTRALIA containing an extract of a letter received by him from The Royal Australasian College of Physicians (see THE MEDICAL JOURNAL OF AUSTRALIA, February 10, 1951, page 242). The Royal Australasian College of Physicians advised that it had been approached by a firm of Australian importers of drugs from abroad, and had been asked to act in an advisory capacity in the allocation of such supplies of cortisone as might become available in Australia through the firm in question. The General Secretary said that he had also received a letter from the South Australian Branch, in which it was suggested that federal control of the importation of the drug should be instituted. One of the pharmaceutical drug houses in Victoria had also expressed concern about the distribution of cortisone, and wished to see that it was used in suitable cases only. Dr. A. J. Collins said that it was a matter which should be arranged by the States, and that basically it was a question of dollars. The Federal Council resolved that the Minister for Trade and Customs should be approached with the request that import licences for cortisone should be granted conditionally upon its use being restricted to cases approved by a panel of highly qualified medical practitioners.

Medical Services to Members of Friendly Societies.

At its meeting in May, 1950, the Federal Council adopted the two following resolutions:

1. That the Federal Council approves of a fee-for-service method of payment at concessional rates being granted to the members of friendly societies for a general practitioner service.

2. That in a concessional service to friendly society members the fee for surgery consultations be 9s. and for domiciliary visits 11s., provided that there shall be provision for annual revision of concessional rates and income limit and that any variation in the one be accompanied by a corresponding variation in the other.

The General Secretary said that he had received a letter dated January 24, 1951, from Dr. H. C. Colville, giving notice that he intended to move for the rescission of the two resolutions. The Victorian Branch had also written on January 25, 1951, informing the Federal Council that the Victorian Branch Council was strongly opposed to any concessional fees being included in a national medical service, and asking the Federal Council to refuse to sanction any such concessions. It also stated that, in view of the actual and impending changes in friendly society practice involving the abolition of income limits, the concessional fees for friendly society members already agreed upon by the Federal Council should be reviewed by the Federal Council. Moving the motion for rescission, Dr. H. C. Colville began by referring to the reaction of members of the Victorian Branch to the arrangements for the pensioner medical service. He said that some members were quite willing to participate, but some comment on the fees had been made. The Victorian Branch Council thought that it was too late to do anything about the matter, but expressed its concern at

the concessions in other directions, and this was the reason for the suggested rescission of the motion. At the time when the motions in question had been adopted at Brisbane, all friendly society lodge practice was on a concessional basis. Since that time many changes had taken place. In Victoria all lodge practice would soon be conducted on a fee-for-service basis, South Australia had such an arrangement, and it was likely that in other States the same condition would prevail. Under such an arrangement with the friendly societies there could be no income limit at all. That being so, it was absurd to have concessions in a service conducted by the Government. Dr. Charles Byrne seconded the motion. Dr. W. F. Simmons read a newsletter which had been sent out to the New South Wales Branch members. There was a group of people in the community who were in difficulties because they were "close to the bread-line". New South Wales did not go all the way with Dr. Colville, but Dr. Simmons agreed that there could be no concessions if the Government undertook all the payment. Dr. Simmons was prepared to support Dr. Colville. He did not think that rescission of the motions in question would bind New South Wales. Dr. A. E. Lee asked what the position of lodge practice in New South Wales was, and Dr. Simmons replied that after April 30, 1951, lodge practice as such would cease. Dr. T. Giblin said that the Tasmanian Branch had advised its members to terminate their agreement. It expected that friendly society lodge practice would soon be on a fee-for-service basis. Dr. Giblin wondered whether, if the motions for rescission were passed, the Federal Council would be going back on its word. Dr. H. R. R. Grieve said that Dr. Giblin was close to the mark, and that the medical profession was in a period of transition in regard to lodge practice. He thought it was clear that to adopt Dr. Colville's motion would be to go too far. Just now people were relatively prosperous, but there was a small class of person who found it difficult to pay his way. Dr. Grieve reminded the Federal Council that the medical profession would have been nationalized long ago, had it not been in the habit of adopting a concessional fee basis. He thought that if the motion was passed it would put New South Wales in the position of being guilty of a breach of faith. Dr. H. C. Colville said that members were labouring under a misapprehension. All the passage of the motion would do was to wipe the slate clean. There would be nothing to prevent the Federal Council from making arrangements for concessional fees for certain special groups. Dr. H. W. Horn agreed and said that he would vote for Dr. Colville's motion. Dr. Charles Byrne did not think that Dr. Grieve's statement in regard to New South Wales was correct. The Council should retain the right to make concessions with any particular body, but the granting of concessions should not be part and parcel of a national health service. The lodges did not want an income limit, because they knew that they could not police it. Sir Victor Hurley supported the motion, and pointed out that the reason for the present state of affairs was that events had moved rapidly.

After Dr. H. C. Colville had replied, the motion was put to the meeting and carried. The Federal Council then decided, on the motion of Dr. H. C. Colville, that the Minister for Health should be informed of the Federal Council's decision in regard to rescission of the two motions, and that the reasons for rescission should be explained to him in a covering letter. On the motion of Dr. C. O. F. Rieger the Federal Council recorded its approval of a fee-for-service method of payment at concessional rates for members of the lower income group, when such income was fixed and could be readily ascertained. On the motion of Dr. Charles Byrne the Federal Council agreed that the Minister for Health should be informed that the Federal Council continued to recognize the right of the Branches to make terms for a concessional fee-for-service scheme with interested non-governmental bodies or groups, whether a national medical service was in existence or not.

British Medical Association.

At its previous meeting in September, 1950, the Federal Council discussed the British Commonwealth Medical Conference, which was to be held at Johannesburg, South Africa, in July, 1951. The Federal Council resolved that it should be represented at that meeting. The General Secretary reported that he had received a letter from Dr. H. Moross, general secretary of the organizing committee of the joint meeting of the British Medical Association and the Medical Association of South Africa, which was to be held at Johannesburg from July 16 to 21, 1951, just after the British Commonwealth Medical Conference. Dr. Moross in his letter gave certain details about the combined meetings. The General Secretary pointed out, however, that in the

British Medical Journal of February 17, 1951, a statement had been issued cancelling the holding of the joint meeting and also the holding of the British Commonwealth Medical Conference. (See *THE MEDICAL JOURNAL OF AUSTRALIA*, March 3, 1951, page 341.)

The Empire Medical Advisory Bureau.

The General Secretary read a letter which he had received from the medical director of the Empire Medical Advisory Bureau, asking for assistance in connexion with publicity for the bureau. He said that he had sent the letter on to the Branches and to *THE MEDICAL JOURNAL OF AUSTRALIA*.

Proposed Affiliation with the Indian Medical Association.

At previous meetings of the Federal Council the proposed affiliation of the Indian Medical Association with the British Medical Association was discussed, but unanimity among the Branches was not reached. The General Secretary reported that all the Branches had now agreed that affiliation should take place.

Appointment of Dr. A. Macrae as Secretary.

The General Secretary reported that he had, on behalf of the Federal Council, congratulated Dr. A. Macrae on his appointment as secretary of the British Medical Association.

British Commonwealth Medical Conference.

The General Secretary reported that he had received a copy of the report of the second British Commonwealth Medical Conference, held at Brisbane from May 23 to 25, 1950.

He had received letters of thanks from Dr. T. C. Routley, Dr. E. A. Gregg and Dr. N. Ahmed.

The Federal Council's share of the cost of the meeting was £623 6s. 1d. sterling. The amount paid in respect of subsistence of delegates and certain travelling expenses was £179 11s. 6d. sterling, leaving a balance of £443 14s. 8d.

Reference has been made under the heading "British Medical Association" to the cancellation of the third British Commonwealth Medical Conference, which was to have been held at Johannesburg in July, 1951.

Organization of the Profession.

The General Secretary reported that he had paid a visit to the South Australian and Western Australian Branches in June, 1950.

The General Secretary read a letter from the Editor of *THE MEDICAL JOURNAL OF AUSTRALIA*, suggesting that periodical photographs of the Federal Council should be taken for record purposes. Reference was made to the photograph of the first Federal Committee published in the Commonwealth Jubilee Number of the journal, and it was stated that in years to come photographs of the Federal Council might be needed when special issues of the journal were published. It was resolved that a photograph of the Federal Council should be taken at the meeting.¹

A letter was received from the Tasmanian Branch deprecating the practice of the sending of letters on major matters of policy between the Branches and not from one Branch to another through the Federal Council. The General Secretary said that he had referred the matter to the Branches. The New South Wales Branch agreed with the Tasmanian Branch. The Western Australian Branch agreed, but added that the practice might be justified when time was short and decision on a certain matter had to be reached. The South Australian Branch agreed with the Tasmanian Branch. The Queensland Branch did not agree, except in certain circumstances which the Federal Council might decide. The Victorian Branch did not agree with the Tasmanian Branch.

Special Groups.

A communication was received from the Oto-Laryngological Society of Australia (British Medical Association), advising of the holding of its inaugural meeting and of its altered title, and sending a copy of its rules.

A letter was also received from the Australian Pædiatric Association, advising of its inaugural meeting and of its decision to withdraw its application for affiliation with the British Medical Association.

The National Health and Medical Research Council.

The General Secretary reported that he had received official reports of the twenty-seventh session of the National

Health and Medical Research Council, held at Sydney on May 24, 1949, and of the twenty-eighth session held at Canberra on November 16 and 17, 1949. He also referred to the report of Dr. W. F. Simmons, the Federal Council's representative on the National Health and Medical Research Council, of the twenty-ninth session held at Sydney on May 17 and 18, 1950, and of the thirtieth session held at Sydney on November 22 and 23, 1950. The two last-mentioned documents had been forwarded to members of the Federal Council.

World Medical Association.

At its meeting in May, 1950, the Federal Council resolved that the appointment of delegates, alternate delegates and observers to attend the fourth annual meeting of the World Medical Association in New York on October 16 to 20, 1950, should be left in the hands of the President and the General Secretary. The General Secretary reported that Dr. Alex Murphy, president of the seventh session of the Australasian Medical Congress (British Medical Association), had been appointed delegate, and that Dr. Hector Stewart, past president of the Western Australian Branch, had also been appointed delegate. Dr. Eric Gartrell, representative of the Editor of *THE MEDICAL JOURNAL OF AUSTRALIA* in South Australia, had been appointed an alternate delegate.

The General Secretary also reported that he had received the minutes of the fourth general assembly and of the ninth and tenth council meetings of the World Medical Association.

The General Secretary reported that he had received and completed *questionnaires* from the Secretary-General of the World Medical Association on the following subjects: status of the medical profession, a hospital survey, pharmaceutical practice survey, activities of the Red Cross in time of peace, medical gas cylinders, and the standards of medical education.

The General Secretary said that he had received from the Secretary-General a copy of the recommendations of the Committee on Medical Education as adopted by the general assembly in October, 1949, and asking for comments. Comments had been obtained from the Branches and sent to the Secretary-General.

The General Secretary said that he had received from the World Medical Association several communications about medical registration. The Secretary-General had sought information on the desirability of publishing a booklet on conditions under which medical and dental practitioners, registered or legally qualified in their own countries, might practise abroad. The Secretary-General had also expressed the wish of the majority of constituent associations that a booklet should be published setting out the conditions under which medical and dental practitioners, registered or legally qualified in their own countries, might practise abroad. The Secretary-General had enclosed a *questionnaire* for completion.

At its meeting in May, 1950, the Federal Council had considered the admission of former enemy nations to membership of the World Medical Association, and had decided to obtain the opinions of the Branches on the question. When the last meeting was held in September, 1950, unanimity had not been reached, but all the Branches were now agreed that former enemy nations should be admitted to membership. An inquiry had also been received from the Parent Body, asking the views of the Council on the question of admission to membership of the World Medical Association of the Japan Medical Association and the Western German Medical Association. The Federal Council adopted a resolution formally approving of admission.

A letter was received from the Council of the World Medical Association, requesting that the Federal Council should recommend to the Federal Government that it should designate a representative of the British Medical Association as one of the delegates to the general assembly of the World Health Organization, which is to meet in Geneva on May 7, 1951. The Federal Council resolved to comply with the request of the council of the World Medical Association, and decided that, subject to all factors being favourable, Dr. L. R. Mallen should be nominated as the representative.

A communication was received from the Secretary-General of the World Medical Association, conveying the copy of a resolution adopted by the fourth general assembly in regard to the activities of the World Medical Association in war, and suggesting that a copy be forwarded to the Commonwealth Government. The Federal Council resolved to adopt the suggestion of the World Medical Association.

A communication was received from the Secretary-General of the World Medical Association, advising that the Nassau Hospital at Mineola, New York, had offered to take two

¹ A photograph of the Federal Council was taken in the Victorian Branch Council Chamber on February 28, 1951.

young foreign physicians for a period of one year and to give them training in orthopaedics or surgery. The Federal Council resolved to send the information to the Branches and to THE MEDICAL JOURNAL OF AUSTRALIA.

The General Secretary reported that he had received from the Secretary-General of the World Medical Association a copy of the resolution of the fourth general assembly disapproving of recommendations of the International Bureau of Military Medicine and the Medico-Juridical Council of Monaco for the establishment of a code of moral principles that would prevail over the medical profession in peace as well as in war.

A communication was received advising that the fifth general assembly of the World Medical Association would be held at Stockholm from September 15 to 20, 1951, and asking for the names of delegates, alternate delegates and observers. The Federal Council resolved that Dr. L. R. Mallen and Dr. E. H. Thomson should be appointed delegates, and Dr. Douglas Galbraith alternate delegate or observer, to attend the assembly in Stockholm. The Federal Council resolved to pay the fares of its delegates and observer from London to Stockholm, together with a daily allowance.

Contract Practice.

Two communications were received from the Western Australian Branch. In the first the rates for attendance for contract practice for the year 1951 were stated. In the second the Branch advised that the contract practice agreement would be terminated on December 31, 1951, or on the introduction of a national health service scheme, whichever was the sooner.

The South Australian Branch advised that the Common Form of Agreement for contract practice had been terminated as at December 31, 1950.

The New South Wales Branch advised that the Common Form of Agreement would terminate as at March 31, 1951.

Salaried Medical Services.

State Medical Services.

The General Secretary reported that he had received from the Victorian Branch a copy of the *Victorian Government Gazette*, Number 819, of November 2, 1950, setting out new salary schedules as determined by the Public Service Board. The information had been sent to the Branches.

Defence Services.

The General Secretary reported that he had received from the Minister for the Army, in reply to a communication, a letter setting out the new rates of pay of medical officers of the Royal Australian Army Medical Corps. The new annual rates of pay for married medical officers, which included marriage separation or provision and clothing allowances of 10s. 3d. per day, were as follows: captain, £1246 to £1355; major, £1437 to £1583; lieutenant-colonel, £1619 to £1801; colonel, £1902 to £2084. Single officers received £45 10s. a year less than these rates. Similar increases had been made in the payment of officers of the Royal Australian Navy and the Royal Australian Air Force medical services. It was pointed out that adequate provision for post-graduate study had not yet been made, but that this was being done. The Federal Council discussed the position of the senior medical officer of the Royal Australian Navy medical service, and expressed the opinion that this officer should hold the rank of surgeon rear-admiral. It was resolved that the Minister for the Navy should be informed of this opinion of the Federal Council.

University Staffs.

The General Secretary reported that he had had some correspondence with the vice-chancellors of the universities and with the Australian Vice-Chancellors' Committee, in regard to the salaries of university staffs. Sympathetic replies had been received.

Medical Research.

The General Secretary reported that he had had correspondence with the Director-General of Health regarding the salaries of medical research Fellows working under the National Health and Medical Research Council. He had been assured that the salaries would be reconsidered, and that when Fellows were of proved ability they would receive up to £1200 per annum.

Psychiatrists in Hospitals and Institutions.

The General Secretary reported that he had received from the Australasian Association of Psychiatrists a letter setting out the opinions of the association in regard to the payment

which should be received by officers in hospitals and institutions. The correspondence had been sent to the Branches.

Repatriation Department.

Medical Benefits for Widows, Widowed Mothers and Orphans of the 1914-1918 and 1939-1945 Wars.

The General Secretary reported that he had received a letter from the Chairman of the Repatriation Commission, advising that in accordance with clauses 8 and 9 of the agreement the rates payable to repatriation local medical officers for the financial year 1950-1951 would be as follows: metropolitan rate, £2 6s. 1d.; country rate, £2 16s. 8d. This information had been sent to the Branches.

Dependants of Deceased Persons Employed in Close Relationship with War Activities.

The General Secretary reported that in December, 1950, he had received from the Chairman of the Repatriation Commission a letter dealing with a proposal of the Commonwealth Government to provide medical treatment for approximately 500 widows, children and widowed mothers of men whose deaths were due to their employment in close relationship with war activities, although they were not members of the forces. These dependants already received pensions and some of the benefits available to dependants of members of the forces. The Chairman of the Repatriation Commission pointed out that the appropriate machinery to implement this provision already existed in the arrangement between the British Medical Association and the Repatriation Commission, which was given effect by an agreement between individual practitioners and the Commission. The Commission asked that consent should be given to include the 500 dependants in an arrangement. The men whose dependants were involved belonged to the following classes: (a) merchant seamen, (b) members of the Citizen forces, part time, not covered by the *Australian Soldiers' Repatriation Act*, (c) Commonwealth employees and representatives of philanthropic organizations attached to the forces, (d) civil aviation personnel (R.A.A.F. Reserve) employed in forward areas, (e) telegraphist employees of Amalgamated Wireless (Australasia), Limited, attached to The Royal Australian Naval Volunteer Reserve, (f) canteen staffs of His Majesty's Australian Ships, (g) New Guinea civilians. The General Secretary said that this letter had been sent to the Branches, and that they had all agreed with the exception of South Australia. Dr. W. F. Simmons expressed the opinion that the service should be rendered, but that it should not be extended any further. After discussion the Federal Council resolved that it would be pleased to recommend to members of the medical profession that they should provide medical service to the dependants of the deceased persons named under the same terms and conditions as were provided for dependants of deceased ex-service personnel, but that it was not agreeable to any further extensions of such services to any other group.

Conference with the Minister for Repatriation.

As the result of correspondence between the Federal Council and the Minister for Repatriation, the Minister had agreed to meet the Federal Council in conference, and he attended on the afternoon of February 26, 1951. The Minister, Senator the Honourable W. J. Cooper, was welcomed by the President, Dr. A. J. Collins, who said that the Federal Council was concerned with the administration of the medical services of the Repatriation Department. A continual inroad of lay control was being manifested, and this was not consistent with the efficiency of the medical department. He invited Sir Victor Hurley to address the Minister. Sir Victor Hurley referred to a report on the administration of the services, which had been issued two or three years previously. He also referred to his own administration of the Royal Australian Air Force Medical Service during the 1939-1945 war. He pointed out that, in those days, the directors had medical control. This was not so at present in the Repatriation Department. The lay side was assuming responsibilities for decisions which were purely medical. These should not be determined or decisions should not be trimmed by a lay official. Senator Cooper, in his reply, after expressing pleasure at being able to meet the Federal Council in conference, said that repatriation had changed its outlook in the last few years. The Public Service Board now had control of the department, as it did of many others. Certain recommendations had been made, and these were being discussed by the Public Service Board. There were in the service 297 medical officers on a permanent and temporary basis. The superintendent of the Repatriation General Hospital had charge of the general running of the hospital. The Chairman of the Repatriation Com-

mission had a position analogous to that of the Adjutant-General in the army. The Principal Medical Officer of the Repatriation Department could go to the Chairman of the Repatriation Commission. Senator Cooper said that he would like to have the opinions of the Public Service on the matter. Dr. A. J. Collins pointed out that the Federal Council had been informed that the Principal Medical Officer had not access to the Commissioner of Repatriation, but to his secretary. Many orders by medical officers had been countermanded. In some States there was what was known as an authorizing officer. After further discussion, in which further reference was made to the Public Service Board, other matters were discussed with the Minister. Dr. W. F. Simmons referred to the forms which had to be used by local medical officers. He pointed out that the details required tended to hold up replies. He mentioned the fee payable to local medical officers, which was now 10s. for each service. He pointed out that the general practitioner's fee was now 12s. 6d. for a consultation in the surgery and 15s. for a visit. The Minister was informed that in the opinion of the Federal Council the fees payable to local medical officers should be 12s. 6d. The Minister then retired.

The Forms Required of Local Medical Officers by the Repatriation Department.

A communication was received from the South Australian Branch, asking the Federal Council to approach the Repatriation Commission with a view to having the number of forms required of local medical officers reduced. It was resolved that an approach to the Repatriation Department with regard to the simplification of forms should be left in the hands of the General Secretary.

The Pensioner Review Report.

A letter was received from the Queensland Branch, inquiring whether an approach had been made to the Repatriation Department for an increase in the fee of 10s. 6d. for the examination required for a completion of Form KK, the war pension medical report. It was resolved that the Repatriation Department should be again approached with the request that the fee for completion of Form KK should be two guineas.

The Terms and Conditions of Service of Visiting Specialists to Repatriation Hospitals.

The General Secretary reminded the Federal Council that at its meeting in May, 1950, it had received a letter from the Repatriation Commission, stating that it was unable to agree with the recommendations of the Federal Council that the fees of visiting medical officers to repatriation general hospitals should be three guineas for the first hour plus two guineas for each succeeding hour or part thereof, and that payment for travelling time should be made in addition to the sessional payments. After discussion it was resolved that consideration of the matter should be deferred until the next meeting, but that in the meantime an approach should be made to the Repatriation Department, requesting that appointments of visiting medical officers to repatriation hospitals should be placed on a permanent basis. The Federal Council also adopted a resolution, in which it expressed the opinion that if the Repatriation Department requested the attendance of a person at a specialist's rooms, the fee paid should be the usual fee charged by that specialist.

The Treatment of Civilian Patients in Repatriation Hospitals.

At previous meetings of the Federal Council, the treatment of civilian patients in repatriation hospitals had been discussed. At the meeting of the Federal Council in September, 1950, it was resolved to approach the Chairman of the Repatriation Commission on behalf of the visiting staffs of repatriation hospitals, with a view first to the making of an agreement for the treatment of personnel under repatriation entitlement, and secondly in order to discuss the treatment of civilian patients who were not so entitled. Sir Victor Hurley and Dr. H. C. Colville were appointed to interview the Chairman of the Repatriation Commission. The Federal Council had before it the report of a conference between the Chairman of the Repatriation Commission and representatives of the Federal Council. At this conference the Chairman of the Commission had been accompanied by two of his officers. At the conference the Federal Council's representatives placed before the meeting a statement entitled "The Place of Medical Treatment in the Repatriation Commission's Activities". In this document

three groups of persons eligible for treatment were stated, as follows:

(a) A discharged member (male or female) of the Australian forces of the 1914 and 1939 wars, also a member who served with certain other forces who was resident of Australia.

(b) South African war veterans.

(c) Widows and children of deceased members and widowed mothers and widowed step-mothers of deceased unmarried members.

The scope of treatment to which these persons might be subjected was as follows:

(a) Treatment is provided for discharged members for disabilities accepted by the Repatriation Commission as related to war service.

(b) Discharged members receiving the full general pensions rate or the special pension may receive medical treatment in the form of active remedial treatment in respect of any disease or disabling conditions not due to war service except an infectious or contagious disease, alcoholism, drug addiction, a chronic or incurable disease requiring treatment in an institution for a prolonged period *et cetera*.

(c) Discharged members and South African war veterans may be treated for pulmonary tuberculosis, though not due to war service.

(d) Widows and children of certain married members and the widowed mothers and widowed step-mothers of certain unmarried members, where the member's death was due to war service, are provided out-patient treatment, but if a bed is available in a repatriation general hospital, in-patient treatment may be given.

In addition there were other patients for whom the Commission had also provided treatment:

(a) Members of the forces on the active list on behalf of the Departments of Navy, Army and Air.

(b) Discharged members of the forces of other countries for which the Commission acts as agent.

(c) Some few tuberculous civilian patients who have been admitted at the request and expense of the Department of Health because of the T.B. campaign sponsored by the Commonwealth and the shortage of beds elsewhere.

(d) A few paraplegics in W.A. at the request and expense of the Department of Social Services pending provision for such cases elsewhere. (The Commission has declined to admit further patients.)

(e) Members of the forces admitted for diagnosis and report, whose disability has not been later accepted, but who are unfit for removal or for whom beds cannot be found elsewhere. They have reluctantly been retained.

(f) Living-in staff of the Commission's medical institutions.

The Federal Council's representatives agreed that the only class of patients listed to which members of the British Medical Association took exception was that mentioned in the third group (c) among the "other patients". These were tuberculous patients. The representatives of the Repatriation Commission replied in regard to these patients as follows:

1. The Repatriation Commission has no control over the admission of civilian patients. It is a matter of government policy and the approach is made by the health departments—both Federal and State, which are presumably unwilling to allow beds to remain vacant in repatriation hospitals, in view of the general shortage of hospital beds.

2. At the present time there are 31 tuberculous civilian patients in repatriation hospitals for the whole of Australia.

3. It is the policy of the Repatriation Commission to maintain the medical services which it has built up at full activity, and it is therefore likely that if in future the number of ex-service patients diminished, the number of civilian patients will be increased.

4. Full-time medical officers in repatriation hospitals are in favour of this arrangement; as 75% of them desire to make the Repatriation Medical Service their career, they are anxious to obtain good clinical material, no matter what its source.

5. As a result of its experience of lodger units the Repatriation Commission would not be willing to set aside separate units or annexes in the repatriation hospitals, under outside control, for the treatment of

civilian patients, and would insist on the treatment of such patients being carried out by its own medical officers, both full-time and visiting. It would not, however, object to special arrangements being made for the payment of visiting medical officers for the treatment of such patients.

The Federal Council's representatives, Sir Victor Hurley and Dr. H. C. Colville, stated that it appeared to them that it was unlikely that the future admission of certain classes of civilian patients to repatriation hospitals could be prevented. A possible solution of the problem would be that the routine care of civilian patients admitted at the request of another government department would be carried out by full-term medical staffs, and that visiting medical officers would be called in as consultants when required and paid adequate fees. The Federal Council's representatives were of the opinion that the authority (the Department of Health and so on) should be responsible for these fees.

The Federal Council adopted the report of Sir Victor Hurley and Dr. H. C. Colville, and extended to them thanks for their services. The Federal Council resolved that the routine care of civilian patients admitted to repatriation hospitals at the request of another government department should be carried out by the full-time medical staffs, and that a medical officer called in as a consultant should be paid a fee per consultation over and above any sessional fee to which he might be entitled. It also resolved that it would take up with the Commonwealth Department of Health the question of the admission of civilian patients to repatriation hospitals.

Local Commonwealth Medical Officers.

Reference was made to the fees payable to local Commonwealth medical officers for the carrying out of certain examinations. The General Secretary reported that he had received a letter from the Director of Social Services approving of the suggestion of the Federal Council that medical officers should be paid for the examination of applicants for invalid pensions the sum of one guinea when the examination was conducted in the doctor's surgery, and 25s. if the examination was conducted in the applicant's home. Mileage was also to be paid.

A letter was received from the New South Wales Branch, asking that consideration should be given to an increase of the fee for examination of applicants for admission into the Commonwealth Public Service, the Commonwealth Bank and the Trans-Australia Air Lines from one guinea to £1 11s. 6d. The Federal Council resolved that the request should be sent to the appropriate authorities.

Workers' Compensation Act.

A communication was received from the Queensland Branch, advising that the total amount allowable for public hospital and medical expenses in the Queensland *Workers' Compensation Act* had been increased from £25 to £50.

Emergency Medical Services.

Sir Victor Hurley reported that as President he had nominated Dr. Byron Stanton and Dr. Ewen Downie as representatives of the British Medical Association on the Pharmaceutical Supplies Panel on the Central Medical Planning Committee. The President's action was approved.

A letter was received from the South Australian Branch, stating that it was understood that the Medical Coordination Committee was again being set up, and asking that the Federal Council take action with a view to having the committee removed from the Department of Health and placed once more under the Department of Defence. On the motion of Dr. C. O. F. Rieger it was resolved that the Federal Council should take action along the lines suggested in the South Australian Branch letter. It was resolved that an approach should be made to the Prime Minister. The Federal Council decided that a copy of the letter sent to the Prime Minister should also be sent to the Minister for Defence and the Minister for Health and the Director-General of Health.

Medical Education.

At a previous meeting the Federal Council had considered a letter from the New South Wales Branch recommending the establishment of a standing committee on medical education similar to that of the Parent Body, whose function would be to formulate standards of medical education in Australia and to keep the Federal Council informed on such matters. The matter had been referred to the Branches,

and it had been agreed that this should be done. The Federal Council resolved to appoint a committee, and it also determined to invite Professor Peter MacCallum to express an opinion on the proposal of the Federal Council to appoint a committee to report on medical education in Australia.

Conditions of Service of Medical Officers of the Armed Forces.

At its meeting in January, 1950, the Federal Council, at the instance of the Victorian Branch, considered a complaint by one of its members about what was thought to be a breach of contract regarding deferred pay in connexion with a short-service commission. The General Secretary had been instructed to inquire into the matter. He had written to the department in February, 1950, and, having received no reply, he had written in May. On May 25, 1950, he had received a reply stating that the matters raised were receiving consideration. By February 1, 1951, no reply had been received, and he had written again, but at the time of the meeting no reply had been received.

The New South Wales Branch forwarded a letter received from a member regarding the refusal of the Department of the Navy to relieve him from service. He had joined the navy in January, 1949, on a short-service commission, the period of which was to be four years. In November, 1950, he had resigned his commission, but had received a communication from the Department refusing to accept his resignation. The reason given had been a shortage of medical officers. It was stated that the terms of the acceptance of the commission included permission to resign except in time of war; the resignation, however, was not to take effect unless it was accepted. The Federal Council decided that the General Secretary should take the matter up with the Department of the Navy.

Fees for the Examination of Recruits to the Royal Australian Navy.

At its meeting in January, 1950, the Federal Council considered the fee payable for the examination of recruits to the Royal Australian Navy, and decided to inform the Minister for the Navy that the Federal Council was of the opinion that the fee should be £1 11s. 6d. In July the General Secretary had written to the department complaining that the rate of payment had not been varied, and stating that the Federal Council was not prepared to recommend the members of the Association to carry out the examination unless the fee was £1 11s. 6d. The General Secretary said that he had received a reply stating that the matter had been referred to the Treasury. He had written again, but had received no reply.

A letter was received from the Western Australian Branch, forwarding copies of correspondence with a member of the Branch who was a district naval medical officer in regard to rates of pay. After discussion the Federal Council resolved that the fees payable to district naval medical officers for services performed on behalf of the Department of the Navy should be two guineas for the first hour and one guinea for any subsequent hour or part thereof.

Registration of Specialists.

At its meeting in May, 1950, the Federal Council discussed the registration of specialists. The matter had been brought before its notice by the Australasian Association of Psychiatrists. Reference at that meeting was made to the registration of specialists in Queensland, and to the recent legislation which had been passed in Western Australia. The Federal Council determined to ask the Branches to consider the problem, so that it might be in a position to state its views if need arose. The General Secretary reported that he had referred the matter to the Branches. The Queensland Branch had agreed with the registration of specialists, and had expressed the view that it should be Commonwealth-wide. The South Australian Branch stated that discussions on the subject had taken place in that State, and that certain rules had been drawn up. The Victorian Branch replied defining a specialist and stating that it was, in its opinion, inopportune to draw up a list at the present time. If a practitioner was to be recognized as a specialist, such recognition should not take place until five years after his graduation, or until he had had at least three years' experience in a special hospital. In addition he should possess a higher degree or diploma in the subject in which he proposed to specialize, or be generally recognized by his fellows as a special expert. The Victorian Branch thought that a practitioner might register for a

second specialty. The New South Wales Branch was opposed to the general registration of specialists. The Western Australian Branch reported that the regulations recently passed in Western Australia had been disallowed, and that at present there was no registration of specialists in that State. The conditions were noted.

Administration and Organization of the Commonwealth Health Services.

A letter was received from the Western Australian Branch, asking that the Federal Council should use its influence to effect transfer of the Rehabilitation Services from the Social Services Department to the Department of Health. The Victorian Branch also drew attention to the administration of the medical services of the Department of Social Services. It was pointed out that the whole matter was a question of lay control, and that lay control was interfering with the efficiency of the services. The Federal Council resolved that the President should be asked to confer with the Minister for Social Services on the matter of the transfer of the Rehabilitation Services from the Social Services Department to the Department of Health.

Fees of General Practitioners for Attendance on Naval Personnel.

A letter was read from the secretary of the Department of the Navy, stating that fees of general practitioners in respect of attendance on naval personnel had been increased. The fee for consultation in the surgery would be 12s. 6d. and for a visit 15s. The fee for a visit at night or on a holiday would be one guinea.

The X-Ray Examination of Appointees to Commonwealth Public Health Services at Country Hospitals.

The General Secretary reported correspondence with the Director-General of Health on the X-ray examination of appointees to Commonwealth Public Health Services at country hospitals. It was requested that films in such cases should be interpreted by radiologists. The Director-General had given an assurance that this would be done.

Council for the Coordination of International Congresses on Medical Sciences.

The General Secretary reported that he had received from the Commonwealth Office of Education the first issue of the quarterly *Bulletin* of the Council for the Coordination of International Congresses on Medical Sciences. The new body had sent a copy of its constitution and also a calendar of congresses for 1950, together with those that would be held in 1951. The object of this calendar was that there would be no clashing of congresses in different parts of the world.

Australian Advisory Council for the Physically Handicapped.

The General Secretary reported that he had received a copy of the report of the fifth annual meeting of the Australian Advisory Council for the Physically Handicapped. This meeting had taken the form of a conference at Launceston and Hobart on February 27 to March 3, 1950.

The Advisory Council also stated that the date of the fifth World Congress of the International Society for the Welfare of Cripples would be held in Stockholm from September 9 to 14, 1951.

The Employment of "New Australian" Doctors.

A letter was received from the Western Australian Branch, forwarding the copy of a letter from a member practising in the country, requesting advice on the employment of displaced persons holding European medical degrees, but not registered in the Australian States, as first-aid attendants in various industries. The General Secretary stated that he had referred this letter to the Branches. The South Australian Branch was the only Branch which opposed the suggestion. The others either raised no objection or left the matter to the discretion of their delegates. On the motion of Sir Victor Hurley, the Federal Council decided to raise no objection to the employment of unregistered European doctors who wished to act as first-aid attendants in industry.

International Cardiac Congress.

The Federal Council had before it the report of Dr. J. Kempton Maddox, who had acted as its representative at the International Cardiac Congress, held at Paris in Sep-

tember, 1950. The report was received. The Federal Council resolved to thank Dr. Maddox.

International Congress of Radiology.

The Federal Council had before it the report of Dr. Colin Macdonald, who had acted as its representative at the International Congress of Radiology, held at London in July, 1950. The report was received. The Federal Council decided to thank Dr. Macdonald for it.

The Examination of Recruits for Compulsory National Service.

At its previous meeting in September, the Federal Council had considered the examination of recruits for compulsory national service. It was pointed out on that occasion that the Department of Labour and Industry, which would be responsible for the call-up of recruits, was anxious to secure the cooperation of the medical profession, and desired the Council to name fees which would be acceptable to medical practitioners undertaking the work. It was desired that the work should be undertaken in evening sessions of two and a half hours by practitioners in private practice. The Federal Council thought that the fee should be two guineas for the first hour and one guinea for every subsequent hour or part thereof. The General Secretary reported that certain rates of payment had been offered by the Department of Labour and Industry. The Federal Council decided to accept these, and to advise the Branches accordingly. For a session of one hour and a quarter or less, the payment was to be two guineas. For more than one and a quarter hours, but not more than one and three-quarter hours, £2 12s. 6d.; for more than one and three-quarter hours, but not more than two and a quarter hours, three guineas; for more than two and a quarter hours, but not more than two and three-quarter hours, £3 13s. 6d.; and for more than two and three-quarter hours, but not more than three and a quarter hours, four guineas. The Federal Council also approved the rates of payment of specialists which had been offered by the Department of Labour and National Service—namely, for the first visit two guineas, for every subsequent visit one guinea. The Federal Council resolved that, in addition to advising the Branches of the rates of payment of medical practitioners for the conducting of the ordinary examinations and specialist examinations, Branch Councils should be asked to arrange for panels of medical practitioners for the carrying out of the ordinary examinations and rosters of specialists for the special examinations.

The Registration of Alien ("New Australian") Medical Practitioners.

At its meeting in September, 1950, the Federal Council considered a letter from the Minister for Immigration, asking the Council's views on the need for and the practicability of obtaining some greater measure of recognition of the medical qualifications of foreign migrants, and of the manner in which such liberalization could best take place. The Federal Council on that occasion appointed a committee, to be known as the Migrant Doctors Committee, to report on the matter. The committee comprised the President, Sir Victor Hurley, the Vice-President, Dr. A. J. Collins, Dr. H. R. R. Grieve and Dr. A. E. Lee. The committee was given powers of cooption. Dr. A. J. Collins, on behalf of the committee, pointed out that the general impression was that the Australian universities could fill the need for the next five to ten years. Graduates from Great Britain were increasing in number; as many were arriving in one year as had come previously in five years. It would be unwise to liberalize the introduction of foreign doctors, as their standard of education was not equal to that of Australian universities. The problem was a large one, and the committee would not be able to present a final report for some months. Dr. H. R. R. Grieve referred to the terms of reference of the committee. The committee was asked to deal specially with the following four aspects: (i) the number of medical practitioners likely to be required for the population in the next ten years; (ii) the capacity of Australian universities to fill these needs; (iii) the number of British migrant medical practitioners that could be attracted to Australia; (iv) what gap, if any, there would remain for the absorption of foreign medical practitioners. He pointed out that the University of Sydney had no quota of medical graduates, and that other Australian universities had. No more students could be taken than were taken at present without a diminution in the efficiency of teaching. Once concessions were made, they would be extended in scope and number. Dr. T. Giblin said that there were rumours of the introduction of a new Act in Tasmania, which would facilitate the introduction and registration of alien practitioners in that

State. Sir Victor Hurley agreed that, whatever happened, there should be no lowering of standards. Dr. Angus Murray laid stress on the standard of efficiency, and pointed out that *locum tenentes* were very scarce. After further discussion the Federal Council resolved that a report in terms of the information furnished by the members of the committee appointed for the special purpose, and consistent with the preliminary letter sent to the Minister by Sir Victor Hurley, should be forwarded to the Minister for Immigration, and that a copy of the report be sent to the Branches for their information.

The Australian Post-Graduate Federation in Medicine.

The General Secretary reported that an invitation had been sent by the Australian Post-Graduate Federation in Medicine to the Federal Council, asking it to become an honorary member of the federation, or alternatively to appoint a guest representative to attend at federation meetings. He said that the invitation to become an honorary member had been accepted, and that Dr. H. C. Colville had attended the meeting of the federation in Melbourne on October 29, 1950.

The Commonwealth Reconstruction Training Scheme.

At its meeting in May, 1950, the Federal Council, at the instance of the New South Wales Branch, discussed a letter from the New South Wales Council of Reconstruction Trainees, an organization formed to protect the interests of returned ex-servicemen receiving the benefits of the Commonwealth Reconstruction Training Scheme. The Federal Council on that occasion resolved to support the Council of Reconstruction Trainees in regard to conditions of work, allowances and so on. The General Secretary drew attention to a Press announcement of increased living allowances, fares and dependants' allowances. These were noted.

Ships' Surgeons.

A letter was received from the New South Wales Branch, drawing attention to the fact that a medical practitioner had been engaged as ship's surgeon on a passenger steamer which had recently resumed its normal interstate trading under the following conditions: (i) The rate of pay £37 10s. a month. Payments to be made twice a month, or as nearly as possible to the fifteenth and thirtieth of each calendar month. (ii) Three weeks' annual leave on full pay. (iii) Engagement to be subject to one month's notice of termination on either side. Professional fees to be charged as follows: 10s. 6d. per visit for first-class passengers, and 7s. 6d. for second-class passengers. It appeared to the New South Wales Branch Council that the remuneration was totally inadequate, and it asked the Federal Council to give consideration to the matter. The Federal Council resolved that the Australian Steamship Owners' Federation should be informed that the Federal Council was of the opinion that the rate of payment of ships' surgeons should be £750 per annum, plus the right of private practice, and that the Federation be further informed that unless the rate of payment was amended forthwith, the Association would be reluctantly compelled to advise its members not to accept appointment as ships' surgeons.

Medical Benefits Fund of Australia, Limited.

A communication was received, advising the Federal Council of the extension of the activities of the fund previously known as the Medical Benevolent Fund of New South Wales, Limited, and of the new scheme of benefits. The conditions were noted.

The Kidnapping of Greek Children.

At its meeting in May, 1950, the Federal Council considered a letter from the Corfu Medical Society, in which an appeal was made on behalf of 28,000 Greek children who had been kidnapped from their homes by Communist bandits and had been transported to various countries behind the Iron Curtain. The letter had been sent to the Federal Council by the Director-General of Health. The Federal Council at that time decided to communicate with the Commonwealth Government, and also to write to the Corfu Medical Society. The Commonwealth Minister had replied that the Australian Government had from the outset been most concerned by the tragic problem. Australia had played a leading role in securing the passage by the United Nations General Assembly of resolutions urging the countries to repatriate the children as soon as possible, with the assistance of the Secretary-General of the United Nations and the International Red Cross organizations. Unfortunately

the efforts of the United Nations and the International Red Cross had so far been fruitless. Towards the end of 1949, however, the Government had been successful in arranging with the Yugoslav Government for a certain number of Greek children in Yugoslavia to join their parents in Australia. The first batch of eighteen children had arrived in Australia in the present year. The Corfu Medical Society had written a letter of thanks to the Federal Council.

Cases and Bags for Surgeons or Physicians.

A letter was received from the New South Wales Branch, forwarding a copy of a communication from a commercial firm, drawing attention to inclusion of surgeons' or physicians' bags with ordinary travelling cases for sales tax purposes. This meant that the goods were subject to a tax of 33½% instead of 8½%. The Federal Council had written to the Minister, who had replied that he had sent the matter to the Treasurer, who would investigate it.

A Red Cross Officer for Korea.

The General Secretary reported that he had received a letter from the Australian Red Cross Society, asking for publicity to help the society to obtain the services of a medical officer for Korea. The letter had been sent to the Branches and to THE MEDICAL JOURNAL OF AUSTRALIA. (See THE MEDICAL JOURNAL OF AUSTRALIA, December 23, 1950, page 945.)

Fee for Certification Under the Lunacy Act.

A letter was received from the Western Australian Branch with reference to fees paid for certification under the Lunacy Act of Western Australia. The Minister had been asked to increase the fee to £2 12s. 6d. in accordance with the decision of the Federal Council, but had refused to do so and had pointed out that in South Australia the fee was £1 11s. 6d., in New South Wales one guinea and in Victoria £2. It was pointed out that some of the Minister's information was not correct, and it was resolved that the General Secretary should inform the Western Australian Branch of the fees payable in the several States.

The Australian College of Speech Therapy.

A request was received from the Australian College of Speech Therapy that favourable consideration should be given to the endeavour of the college to establish and to maintain professional status for qualified speech therapists in Australia. It was resolved that the request of the college for the recognition of the professional status of speech therapists should be approved.

The Australian Dietetic Council.

A communication was received advising the Federal Council of the inaugural meeting of the Australian Dietetic Council and of its objects, and assuring the Federal Council of its willingness to cooperate with the British Medical Association in any activities relating to the field of nutrition and dietetics.

Vaccination Against Smallpox.

A letter was received from the Queensland Branch, requesting that the Commonwealth Department of Health be asked to appoint medical practitioners other than full-time Commonwealth officers to satisfy the requirements of the International Certificate of Vaccination. It was resolved that further information on the subject should be sought from the Director-General of Health.

The Medical Examination for Pilots' Licences for Aircraft.

A letter was received from the Aircraft Owners and Pilots' Association of Australia requesting reconsideration of the fee of one guinea to be charged for examination for renewal of licence (Form 34A). It was pointed out that there were special circumstances connected with the renewal of these licences, and that the trainees were under considerable expense. It was resolved that in view of the special circumstances set out in the letter to the Federal Council, the fee charged for the completion of C.A. Form 34A should be one guinea, in lieu of the £1 11s. 6d. previously decided upon.

The Retirement of Sir Victor Hurley.

Dr. A. J. Collins said that a letter should be sent to Sir Victor Hurley, expressing the great regret of the Federal Council that he was unable to offer himself for reelection

as president. The Council wished to place on record its deep appreciation of the valuable services rendered by Sir Victor Hurley to the Federal Council and to the medical profession at large. The motion was moved by Dr. H. R. R. Grieve, who said that Sir Victor Hurley had been president during an historical period of the Federal Council. His path had been one of difficulty. It would have been impossible for the medical profession to emerge from its difficulties intact, as it had done, without the wise direction of Sir Victor Hurley. Dr. H. C. Colville seconded the motion, which was carried unanimously.

Votes of Thanks.

It was resolved that the thanks of the meeting should be extended to the President, Dr. A. J. Collins, for presiding.

It was also resolved that the thanks of the Council be extended to the Victorian Branch Council for its hospitality and for the use of its offices, and to Sir Victor Hurley, Dr. H. C. Colville and Dr. C. Byrne for their hospitality.

Date and Place of Next Meeting.

It was resolved that if possible the next meeting of the Federal Council should be held in Adelaide, and that the first meeting in 1952 should be held in Hobart. The dates in each instance were left in the hands of the President.

World Medical Association.

The following information is published at the request of the Secretary-General of the World Medical Association.

The World Medical Association Fifth General Assembly.

The Swedish Medical Association will be host to the Fifth General Assembly of the World Medical Association when it convenes in Stockholm, Sweden, on September 15 to 20, 1951. The General Assembly will consider problems of medical education, both undergraduate and post-graduate, medical social security, and cooperation with intergovernmental organizations such as WHO and UNESCO. Tentative plans are also being made to devote at least half a day to a scientific programme, with presentation of papers relative to the most recent developments of medical science. On September 21, 1951, the World Medical Association will sponsor a meeting of the medical editors of the world. A special programme is being arranged by some of the world's outstanding medical editors. Further details relative to this meeting may be obtained from the Secretariat of the World Medical Association at 2 East 103rd Street, New York 29, New York, or from Dr. J. G. Hunter, General Secretary, Federal Council of the British Medical Association in Australia, 135 Macquarie Street, Sydney.

Training Positions.

The World Medical Association announces that training positions have been made available to it for two foreign medical practitioners—one in orthopaedics and one in surgery. These positions are available at the Nassau Hospital, Mineola, Long Island, New York. This is a 260-bed general hospital, supported by private funds. The hospital is about twenty miles from New York City. The training period is for one year. Applicants must furnish their own transportation. The hospital will provide room, board and a small honorarium. Applications must be submitted to the World Medical Association, through the national medical association of the country of the applicant. This offer is not for practitioners who wish to migrate to the United States, but only for those who, after the period of training, desire to return home to practise. All applicants must be able to speak English.

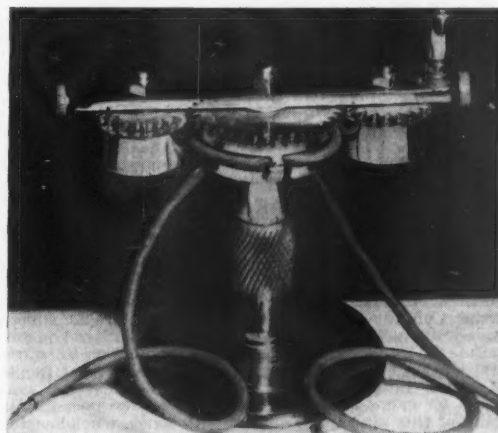
Correspondence.

THE "FALCOS" TRANSFUSION PUMP.

SIR: The undersigned Greek engineer, residing in Salonika, has manufactured an instrument for the ideal blood transfusion, which is the best machine for transfusion in result, simplicity, strength and security. This pump transfuses directly whole unmodified blood, as well as blood modified with citrate from bottles (plasm).

This outfit (transfusion blood pump) is built according to all requirements of science and art. No similar machine has such convenience as regards placing and removing of the elastic tube, getting in and releasing of blood, does not need flanges nor any support to hold in a steady position. It can simply be cranked around the central drum (from outside) and on its top there are rotating two small rollers with a compulsory rotation around them and around the central drum, by means of gears. As the rollers are moved by a crank handle they rotate against the tube, which is compressed, "milking" the blood in a clockwise direction. The tube is calibrated to pump one cubic centimetre, which takes in the fluid with a complete crank turn (each round turn can pump two cubic centimetres if required).

There is used a tube of small diameter, in order that it will not take in a great amount of blood, and to have a quicker transport of blood from the transmitter to receiver, so that within two seconds the blood taken in the transmitter enters the receiver in its warm and physiological condition. At the same time the blood run is regulated by drops when the blood is mixed with citrate. In no other outfit of this kind can a tube of such small diameter be used. The only part of the instrument that needs cleansing and releasing is the rubber tube.



All machines of this kind manufactured so far are defective, because the tube has to be held with two semi-circular flanges, not so secure as those of the De Bakey machine, a thing which requires great care and skill in its use, or by binding the tube at one end, to prevent tubes moving at the time of "milking" the blood and rotation of rollers; but, in both cases the tube, when it milks, due to compression is driven by and consequently becomes longer, loses its shape, and its diameter gets smaller. Thus, instead of giving out two cubic centimetres on each turn as in the first rotation, it starts changing shape and lessens to 1.4 cubic centimetres and later to one cubic centimetre, and its output at last will be that of the width of the tube and the hole at the time when the process of taking in and releasing stops. Therefore, all the "outfits" made so far are useless because of the said complication and people would not use them, primarily because the tube is placed inside the drum and cannot be held in its proper place, being pressed internally by the two or three rollers (cylinders) towards the outer linings; this makes the tube lose its diameter because the tension makes the tube form a trigon, pressing it away from the lining of the drum, as soon as the small rollers pass by, so there is nothing steady in them. But such a thing never happens to the "Falcos" outfit, because the length of the tube which is around the central drum is always in contact with its external surface and it does not get smaller, nor changes its shape, never gets out of its place, and would never cause any complication. So there is no sign of defect in this instrument. Therefore, from the very first turn up to 10,000 turns there is no change in output, no matter how rapid the turns are (from 10 drops per minute to 100 grammes per hour).

With the aid of this outfit ("Falcos" pump) there can be blood transfusion to wounded persons in mobile ambulances, moving planes *et cetera*, with no danger whatsoever. The new "Falcos" outfit for blood transfusion is an improved instrument of the one about which Lieutenant-Colonel

Franklyn V. Stonham, officer in charge of the surgical division of a general hospital, Central Mediterranean Forces, wrote in *THE MEDICAL JOURNAL OF AUSTRALIA*, Sydney, on January 25, 1947.

Salonica,
Greece,
March 2, 1951.

Yours, etc.,
THEE. N. FALCOS.

ANOTHER REPORT ON NURSING.

Sir: Your article under the above heading, which appeared in the issue of March 17, 1951, brings out many problems which have been exercising the minds of members of the nursing profession in Australia for some time. We agree with your comments and would like to show how some of the problems are being tackled in this country by the College of Nursing, Australia.

The College was established in 1949. It is a body of Fellows which is governed by a council elected by the Fellows. This council is made up of representatives of all States and has an independent chairman. During the early days when plans were being drawn up we received a great deal of help and advice from the British Medical Association, The Royal Australasian College of Physicians and the Royal Australasian College of Surgeons, and at the present time Sir Victor Hurley represents the British Medical Association on our Education Committee.

The article states that "nowadays nurses can undertake special courses of training in administration and in the teaching of nursing". In 1950 three courses were held here, and these were based on those run by the Royal College of Nursing, London, and adapted to our needs in Australia: (i) nursing administration course (one academic year), (ii) sister tutor course (one academic year), (iii) ward sister course (six months). We are continuing with these courses, and students from all over the Commonwealth and from overseas are admitted. Up to 1949, full-time courses of this kind were not available in this country, and due to the magnificent work of the Florence Nightingale Memorial Committee of Australia, the Australian Red Cross Society and the Centaur War Nurses' Memorial Trust, sufficient funds were made available after the war to send some 35 students to England to take either a course in nursing administration or the sister tutor course. Now that facilities for training in this country are available, it is no longer essential for every nurse wishing to undertake post-graduate training of this kind to go abroad. We agree wholeheartedly, however, with the suggestion that Fellowships should be available for nurses to study in other countries as well, and we would recommend that they be made available for study tours by senior members as well as for specific courses.

"The provision of refresher courses leaves much to be desired." It is because of this fact that the College of Nursing, Australia, is now considering the whole question and is drawing up plans for such courses. Where hospitals provide training of a specialist nature, for example, paediatrics, orthopaedics, tuberculosis nursing, it is hoped that they will also find it possible to arrange short refresher courses in their own particular specialty. We look forward to the day when a variety of courses are available, and when every nurse holding a position of responsibility in a hospital is required to attend a refresher course every five years. Other courses which we hope to establish before long are a course for midwife teachers and a course in public health nursing. There is little opportunity at present for full-time training in the public health field, and it is hoped that employing authorities will encourage and assist those who may wish to avail themselves of this training. I shall be pleased to supply particulars of these courses when they are available, or details of the present courses to anyone who may like to have them.

Lastly, the College is about to begin some research into the question of problems of selection. This will be done in conjunction with psychologists and experts in vocational guidance. This is a long-term project, and it is not likely that there will be any definite results for some time. However, with the cooperation of some of the nurse training schools and others interested, it is hoped that the results will be of considerable value in the future.

Yours, etc.,

PATRICIA D. CHOMLEY,
Director, College of Nursing,
Australia.

431 St. Kilda Road,
Melbourne,
April 10, 1951.

GESTATIONAL RUBELLA AND THERAPEUTIC ABORTION.

Sir: Some private correspondence has arisen out of my previous letter (January 20, page 132); and Dr. C. Swan (1949) has kindly supplied me with the data on which he bases his conclusion that, after rubella in the first three months of pregnancy, 77% of the children will have congenital abnormalities.

But all statistics based on the memory of the patient or the doctor are useless because (i) rubella is often wrongly diagnosed, and (ii) the mother of an abnormal child is likely to remember a rash in early pregnancy while the mother of a normal child is likely to forget it. There is only one way to discover the incidence of abnormalities—to follow through to full term a reasonable number of pregnant women who have had rubella, and to find by observation the proportion of malformed children. In five instances this has been done; though the numbers are not large, they are sufficient to indicate that the threat of malformations has been exaggerated. The figures quoted are for the first three months of pregnancy. Seven cases of foetal death—not significant because this is the expected miscarriage rate—have been excluded.

Author.	Number of Cases.	Congenital Malformations.
Aycock and Ingalls (1946)	2	1 (mentally retarded).
Fox and Bortin (1946)	8	1 (hydrocephalus, still-born).
Ober and others (1947)	16	5 (bilateral cataract (2), heart lesions (2), deafness (1)).
Grönvall and Selander (1948)	11	0
McLorinan (1950)	3	0
Total	40	7

In 432 instances of foetal malformation following rubella, there is no other case of hydrocephalus (see Swan, 1949). This one therefore should be excluded from the list and regarded as a fortuitous foetal death. The other six cases are of recognized post-rubella anomalies; for every one of them there are nearly six normal children.

Abortion has been recommended by scientists, not as a scientific procedure, but to save women from worry. But Packer (1950) found two congenital abnormalities out of six cases of morbilli in the first three months of pregnancy. Shall we soon have abortions recommended after all virus diseases in early pregnancy? And if, on the imprimatur of a scientist, worry is a sanction for abortion, the unmarried mother and the anxious wife cannot be excluded.

Through a strange bias against morality, and for emotional reasons only, 39 children must be sentenced to die because six of them may be blind or deaf, or may require operations on their eyes or their hearts. So intensely do we have to hate these abnormalities that, not only must we deprive the possessors of their right to life and happiness, but in our fury we must lay about us blindly and slaughter six innocents with every "guilty" child. This mystic though dogmatic belief is held by pure faith and not by reason; it has all the weight of a false religion which demands human sacrifice.

"Stanhill",
34 Queens Road,
Melbourne.
March 28, 1951.

Yours, etc.,
M. KELLY.

References.

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Ober, R. E., Horton, R. J. M., and Feemster, R. F. (1947), "Congenital Defects in a Year of Epidemic Rubella", *American Journal of Public Health and The Nation's Health*, Volume XXXVII, page 1328.

Swan, C. (1949), "Rubella in Pregnancy as an Aetiological Factor in Congenital Malformation, Stillbirth, Miscarriage and Abortion", *The Journal of Obstetrics and Gynaecology of the British Empire*, Volume LVI, pages 341 and 591.

ICTERUS GRAVIS NEONATORUM: REPORT OF A CASE REQUIRING REPLACEMENT TRANSFUSION.

SIR: In "Reports of Cases" in *THE MEDICAL JOURNAL OF AUSTRALIA* of March 31, 1951, J. K. Fullager and I. L. Chapple describe a case of *icterus gravis neonatorum* requiring replacement transfusion. On the history of the case as presented and the relatively late onset of jaundice, together with the absence of nucleated red blood cells in the circulating blood, one feels that a "simple" transfusion of 100 millilitres of Rh-negative blood would have been adequate and just as effective. The use of Rh-negative blood from a male donor is now regarded as being less effective than Rh-negative blood from an unaffected female donor. Finally, in replacement transfusion, it is usual to replace with 500 to 600 millilitres of blood and safer to administer less blood than is withdrawn, estimating the venous pressure with a manometer before and after transfusion. A blood sample taken from the heel is surely safer than a fontanelle puncture on the third day of life.

Replacement transfusion is a very valuable weapon in the treatment of haemolytic disease of the newborn, but gives its best results when started within the first twelve to twenty-four hours of life.

Yours, etc.,

185 Macquarie Street,
Sydney,
April 9, 1951.

NORMAN CUNNINGHAM.

A CORRIGENDUM.

SIR: It has been brought to the notice of this Board by Dr. A. E. Finckh, 227 Macquarie Street, Sydney, that in the 1950 issue of the Register of Medical Practitioners for New South Wales, the date of his degrees is shown as M.B., Univ. Sydney, 1950, when it should be M.B., Univ. Sydney, 1905.

He has also asked that the Board should make a statement in *THE MEDICAL JOURNAL OF AUSTRALIA* referring to this mistake, and you might perhaps be good enough to consider inserting a corrigendum in the journal in this regard.

Yours, etc.,

G. R. FLEMING,
Secretary, New South Wales
Medical Board.

52 Bridge Street,
Sydney,
April 10, 1951.

LOBECTOMY FOR HYDATID DISEASE OF THE LUNG.

SIR: I was interested to read Mr. M. P. Susman's indications for lobectomy in the treatment of pulmonary hydatid disease as published in his article "Lobectomy for Hydatid Disease of the Lung" in *THE MEDICAL JOURNAL OF AUSTRALIA* on March 17, 1951.

I feel that the principles to be followed in the treatment of this disease are (a) the eradication of the parasite and (b) the subsequent return to "maximum normal" lung function. It may be necessary to sacrifice lung tissue in order to obtain normal lung function, and I think Susman's interpretation of the indications for resection being directed towards this end are wiser than the conclusion arrived at by Waddle (1950) as quoted by Susman.

From my small series of the treatment of 22 patients suffering from 31 pulmonary cysts, I have arrived at certain conclusions concerning indications for resection in pulmonary hydatid disease. I usually list these indications as follows: (a) giant cysts; (b) ruptured cysts with infected dead space of long duration; (c) uncontrolled pulmonary hæmorrhage during a conservative operation (a condition

I have not experienced, but obviously requiring resection); (d) multiple complicated cysts in one lobe; (e) destroyed lobe; (f) failure of conservative surgical treatment (this includes residual bronchiectasis and residual infected dead space).

In fact these indications all represent the failure of or anticipated failure of conservative treatment resulting from irreversible damage to lung tissue. However, in children I lean very definitely towards conservative surgical treatment because the disease is probably of shorter duration and because the ability of the lung tissue to recover is much greater.

My experience with Barrett's method of enucleating unruptured cysts intact must be more fortunate than Susman's because I have found this a most satisfactory procedure. I have attempted it in eight cases. One of these I abandoned in favour of resection when I discovered the size of the cyst and the thickness of the adventitious capsule, whilst in one other case the cyst ruptured during the manipulation. The six cases in which this manoeuvre proved successful progressed so well that I consider this to be the operation of choice where unruptured cysts are encountered, and I am convinced that with added experience the number of failures using this method will be reduced proportionately.

Yours, etc.,

H. D. SUTHERLAND, M.S., F.R.C.S.,
F.R.A.C.S.
170 North Terrace,
Adelaide,
March 30, 1951.

VISIT OF PROFESSOR B. W. WINDEYER AND DR. M. H. JUPE.

SIR: In the last two issues of the monthly bulletin of the British Medical Association (New South Wales Branch), circulated to all members in this State, there has been inserted by the Post-Graduate Committee in Medicine in the University of Sydney a notice, under "Overseas Lecturers", that Professor B. W. Windeyer and Dr. M. H. Jupe are lecturing in Sydney on May 17, 1951.

As the notice reads, it suggests that all credit for sponsoring the visit of these very important people is due to the Post-Graduate Committee.

Professor Windeyer and Dr. Jupe are arriving in Australia by permission of the Faculty of Radiologists (London), of which Professor Windeyer is president, and at the invitation of the College of Radiologists (Aust. and N.Z.). They will, for the first time outside England, hold examinations for the highest degree in radiology, namely, the Fellowship of the Faculty. The examinations are to be held in Melbourne, but it seems assured that visits will be made to all States and to New Zealand.

In addition to the evening mentioned by the British Medical Association, other dissertations on more technical subjects are being delivered to members of the College.

It must be gratefully mentioned that the Baker Trust has assisted the College in the financial responsibilities of the tour of Professor Windeyer and Dr. Jupe.

Yours, etc.,

A. T. NISBET,
Hon. F.F.R. (Lond.).
31 Stanhope Road.
Killara,
New South Wales.
April 14, 1951.

NITROUS OXIDE-THIOPENTONE-CURARE ANÆSTHESIA: A PRELIMINARY REPORT ON AN APPARENTLY UNSATISFACTORY TECHNIQUE.

SIR: With reference to Dr. Pratt's article on this subject in *THE MEDICAL JOURNAL OF AUSTRALIA* of April 7, 1951, I would like to mention several points in connexion with the use of nitrous oxide in the manner described.

When a mask is applied to a patient's face and nitrous oxide and oxygen administered in a continuous flow at the rate of 500 cubic centimetres each in a closed system with overflow, the concentration of nitrous oxide in the system gradually rises till equilibrium is reached. Experimental gas analyses suggest that this takes a considerable time, approximately twenty minutes. During that period the oxygen content of the system varies, depending upon the

initial oxygen content of the patient and machine. If both contain air, an oxygen analysis of the inhaled gases will show a gradual rise of oxygen till equilibrium is reached at about 30%. If the machine is filled with oxygen and the patient has been breathing oxygen, the oxygen content of the inhaled gases will be high at first and will fall to about 30% as equilibrium is attained. During the period of establishment of equilibrium the nitrous oxide content is not necessarily equal to the 100 minus the oxygen percentage, as there is usually at the same time some nitrogen in the system. It is suggested that the desired concentration of nitrous oxide in the system can be attained much more quickly by flowing the gases faster at first (say two litres of oxygen and four litres of nitrous oxide for five minutes) and then slowing them.

Yours, etc.,

W. H. J. COLE,
Assistant Anaesthetist.

Royal Melbourne Hospital,
Melbourne,
April 11, 1951.

ARTHUR WILSON MEMORIAL FUND.

SIR: As stated in THE MEDICAL JOURNAL OF AUSTRALIA of March 31, 1951, the purpose of the Arthur Wilson Memorial Fund is to establish an institute of research in obstetrics as a memorial to one of the greatest obstetricians Australia has produced. Donations, which may be sent to Dr. C. K. Churches, honorary treasurer, 122 Flinders Street, Melbourne, C.I., will be acknowledged in this journal.

Yours, etc.,

C. K. CHURCHES.

122 Flinders Street,
Melbourne, C.I.,
April 10, 1951.

The following donations have been received and are acknowledged with thanks: previously acknowledged 1955 5s., Dr. F. Lawson £100, Dr. G. Foreman £50, Dr. J. W. Johnstone £50, Dr. Bruce Anderson £20, Dr. F. Bacon £10 10s., Dr. R. C. Brodie, £10 10s., Dr. L. B. Inglis £10 10s., Dr. W. W. S. Johnston £10 10s., Dr. and Mrs. Sydney Crawcour £10 10s., Mrs. J. H. Nattrass £5 5s., Dr. G. Raleigh Weigall £5 5s.

PINK DISEASE: THE MANIFESTATION IN OLDER CHILDREN AND THE ESTIMATION OF THE BLOOD ADRENALINE CONTENT.

SIR: May I be allowed to express a few opinions on Dr. Donald Cheek's article on chloride deficiency. While I disagree that these cases are a variety of subclinical pink disease, I wish to stress the fact that the syndrome does exist, and in Tasmania at least is fairly common. Having collected about 20 cases in the last three years and seen the dramatic response to salt therapy in these cases with a typical clinical history—his case histories and mine and the response to treatment are almost parallel—I felt quite sure I had discovered a new syndrome, but as usual there is nothing new in medicine. However, I wish to congratulate him on adding a new chapter to the text-books on paediatrics, and will add my small contribution in an article shortly.

Yours, etc.,

PAUL DORNEY, M.D., M.R.A.C.P.

148 Macquarie Street,
Hobart,
April 6, 1951.

BROMIDES AND CHLORAL HYDRATE.

SIR: The attention of the profession should be called to the increasing use of the bromides and chloral hydrate as drugs of addiction. These drugs, sold singly or in combination, under a number of trade names, can be purchased openly in New South Wales without a prescription. They are especially used by alcoholics as a sedative whilst drinking, or after they have given up alcohol. Such patients habitually use overdoses, and in many they replace the alcohol as a habit. For this reason, the use of sedatives and hypnotics in the treatment of alcoholism is seldom advisable.

As cases of opiumism and chloral hydrate poisoning are becoming increasingly more common, the question arises whether the sale of these drugs should not be more rigidly controlled.

Yours, etc.,

S. J. MINOGUE.

195 Macquarie Street,
Sydney,
April 12, 1951

Post-Graduate Work.

THE POST-GRADUATE COMMITTEE IN MEDICINE IN THE UNIVERSITY OF SYDNEY.

Clinical Meeting at Balmoral Naval Hospital.

THE Post-Graduate Committee in Medicine in the University of Sydney announces that a clinical meeting will be held at the Balmoral Naval Hospital on Tuesday, May 15, 1951, at 2 p.m., when Dr. S. H. Lovell will speak on "Some Surgical Conditions of the Inguino-Scrotal Area". Clinical cases will be shown at 4 p.m., after afternoon tea. All members of the medical profession are cordially invited to attend.

Medical Societies.

THE AUSTRALIAN ASSOCIATION OF NEUROLOGISTS.

THE second scientific meeting of the Australian Association of Neurologists will be held in the Maitland Lecture Theatre, Sydney Hospital, on Tuesday, April 10, 1951. The programme will be as follows: 11.15 a.m., "Peripheral Neuritis and Bronchial Carcinoma", Dr. Gilbert Phillips; 11.45 a.m., "Hallevorden-Spatz Disease and its Relation to Wilson's Disease", Dr. Leonard B. Cox; 2.15 p.m., "Lesions of Nerves in Typhus and Their Pathology", Dr. K. B. Noad; 2.45 p.m., "What a Cerebellar Section Might Reveal", Dr. Oliver Latham; 3.15 p.m., "Some Unusual Subdural Hematomas", Dr. John A. Game; 4.15 p.m., "Examination of Twins Joined at the Vertex", Dr. E. Graeme Robertson.

University Intelligence.

UNIVERSITY OF MELBOURNE.

THE seventeenth Beattie-Smith Memorial Lectures on Insanity will be given by Dr. John F. J. Cade, Medical Superintendent, Repatriation Hospital, Bundoora, on Monday, May 7, 1951, when the subject will be "Research in Psychiatry", and the chairman will be Professor R. D. Wright, and on Monday, May 14, 1951, when the subject will be "The Problem of Schizophrenia", and the chairman will be Professor G. W. Paton, Acting Vice-Chancellor. The lectures will be given in the Anatomy Theatre, University of Melbourne, at 8.15 p.m.

The following information has been taken from the *University of Melbourne Gazette* of April 1, 1951.

Dr. F. J. R. Hird returned from Cambridge at the end of February to take up the newly created senior lectureship in agricultural biochemistry. The first recipient of the Sir John and Lady Higgins Scholarship—which he held for four years—Dr. Hird carried out important researches at Cambridge on the mechanisms underlying the synthesis of proteins in biological systems, for which he was awarded the Ph.D. degree of that university. His recent publications in this field have aroused the keenest interest among biochemists in England and America.

Mr. J. W. Legge, a graduate of this university, commenced duty in January as senior lecturer in the Department of Biochemistry. Mr. Legge has had considerable research experience mainly with blood pigments and in enzymology, and during the war did valuable work with the Chemical Warfare Unit of the Australian Army. From 1946 to 1948

he was in Europe as Wellcome Foundation Fellow, chiefly at the University of Cambridge, and on his return to Australia was appointed to a senior Fellowship with the Australian National Health and Medical Research Council. Among his publications is a standard work on "Hematin Compounds and Bile Pigments" written jointly with Dr. Lemberg, of Sydney.

The Director of Visual Aids, Mr. N. H. Rosenthal, has been granted three months' leave of absence as from March 19, and his services have been made available to the Royal Australian Air Force. Mr. Rosenthal will be sent to America and the United Kingdom on matters associated with the visual training of Air Force personnel.

The following staff matters have been approved by Council: Dr. J. Gallant appointed clinical supervisor at the Alfred Hospital; Miss S. G. Fawcett appointed senior lecturer in the Department of Botany; Dr. W. M. Rose has resigned his senior lectureship in the Department of Pathology; Dr. J. W. Johnstone resigned the Acting Professorship of Obstetrics and Gynaecology as from February 28; Mr. J. B. Turner has resigned as independent lecturer in surgical anatomy.

Professor Trikojus will be on sabbatical leave as from April 14.

The first awards have been made of the Sweet Fellowships, each valued at £500 a year. The Elizabeth Mary Sweet Fellowship in Medicine has been awarded to Dr. Dora Bialestock, of the Department of Pathology, who will continue her work on serological and biochemical techniques on animal subjects, particularly in relation to nephritis. The Georgina Sweet Fellowship in Economic Zoology goes to Mr. N. Dobrotvorsky, a Russian-born entomologist, who came to Australia as a migrant some twelve months ago. He holds the equivalent of a Master of Science degree of the University of Minsk, and was engaged as demonstrator in zoology there. In 1931, as assistant at the White Russian Academy of Science, he was found politically "unreliable" and sent as a senior entomologist to Alma-Ata in far-eastern Russia. He is the author of a number of papers on insect

diseases of plants. Each of the Fellows will work at the university under the direction of the head of the department concerned.

Lectures in microscopy will be given during the second and third terms by Mr. E. Matthaël. The course is intended for biological and medical research workers, with emphasis on laboratory application of the microscope. Ten lectures and demonstrations in the second term will deal with the following subject matter: (i) the limits of microscopical resolution; (ii) the testing of microscopes for spherical and chromatic aberration, centring of lens systems and alignment of microscope; (iii) critical illumination; (iv) darkground microscopy; (v) phase contrast microscopy; (vi) fluorescence microscopy; (vii) the use of polarized light for microscopic examination of biological material. Some additional lectures in the third term will discuss (i) photomicrography and (ii) ultra-violet light in microscopical analysis. A fee of £3 3s. will be charged for the course, and applications should be forwarded to Mr. Elford, Secretary of the Faculty of Science, not later than May 12, 1951. A limited number of students only can be accepted.

The Association of Universities of the British Commonwealth has advised that a limited number of copies of the Commonwealth Universities Year Book, 1951, are available. The ordinary price is 37s. 6d. (sterling), but members of the university staff may receive copies for 25s., plus one shilling postage and packing. Order forms may be had from the Registrar's office.

Obituary.

HUGH STANISLAUS BOURKE.

We regret to announce the death of Dr. Hugh Stanislaus Bourke, which occurred on April 3, 1951, at Hawthorn, Victoria.

DISEASES NOTIFIED IN EACH STATE AND TERRITORY OF AUSTRALIA FOR THE WEEK ENDED MARCH 24, 1951.¹

Disease.	New South Wales.	Victoria.	Queensland.	South Australia.	Western Australia.	Tasmania. ²	Northern Territory. ³	Australian Capital Territory.	Australia. ⁴
Ankylostomiasis
Anthrax
Beriberi
Bilharziasis
Cerebro-spinal Meningitis	..	1	..	..	..	..	..	..	1
Cholera
Coastal Fever(a)	3	..	..	..	..	..	3
Dengue
Diarrhoea (Infantile)	6(6)	..	3(2)	..	..	..	9
Diphtheria	6(3)	4(4)	6(3)	1(1)	6(1)	..	..	..	23
Dysentery (Amoebic)
Dysentery (Bacillary)	..	1(1)	1(1)	..	3(2)	..	..	..	5
Encephalitis Lethargica	..	2(1)	..	..	..	..	..	..	2
Erysipelas
Filaria
Helminthiasis
Hydatid
Influenza
Lead Poisoning
Leprosy
Malaria(b)	1
Measles	15(13)	..	..	..	..	15
Plague
Poliomyelitis	58(31)	4(1)	30(12)	22(10)	..	..	..	2	116
Psittacosis
Puerperal Fever
Rubella(c)
Scarlet Fever	13(5)	14(6)	5(2)	1	4(2)	..	..	..	39
Smallpox
Tetanus	3
Trachoma
Tuberculosis(d)	33(22)	8(4)	9(7)	7(6)	7(4)	..	..	..	64
Typhoid Fever(e)	1(1)	..	..	..	..	..	1
Typhus (Endemic)(f)	1	..	5	1	..	..	..	..	7
Undulant Fever	1(1)	..	..	..	..	..	1
Well's Disease(g)
Whooping Cough	2(1)	..	..	..	..	2
Yellow Fever

¹ The form of this table is taken from the *Official Year Book of the Commonwealth of Australia*, Number 37, 1946-1947. Figures in parentheses are those for the metropolitan area.

² Figures not available.

³ Figures incomplete owing to absence of returns from the Northern Territory and Tasmania.

⁴ Not notifiable.

(a) Includes Moxman and Sarina fevers. (b) Mainly relapses among servicemen infected overseas. (c) Notifiable disease in Queensland in females aged over fourteen years. (d) Includes all forms. (e) Includes enteric fever, paratyphoid fevers and other *Salmonella* infections. (f) Includes scrub, murine and tick typhus. (g) Includes leptospirosis, Well's and para-Well's disease.

JAMES ALFRED LARWILL.

We regret to announce the death of Dr. James Alfred Larwill, which occurred on April 7, 1951, at Ivanhoe, Victoria.

Nominations and Elections.

THE undermentioned have applied for election as members of the South Australian Branch of the British Medical Association:

- Calder, Shirley, M.B., B.S., 1950 (Univ. Adelaide), Eden Hills.
 Robinson, Donald Neil, M.B., B.S., 1948 (Univ. Adelaide), c.o. National Bank, Unley Road, Unley, South Australia.
 Brandstater, Bernard John, M.B., B.S., 1950 (Univ. Adelaide), 53 Porter Street, Parkside.
 Dewar, Colin Chudleigh, M.B., B.S., 1949 (Univ. Adelaide), 43 Elmo Avenue, Unley Park.
 Heitmann, Dorothea Smith, M.B., B.S., 1949 (Univ. Adelaide), 218 Henley Beach Road, Torrensville.
 Prest, Elizabeth Maurine, M.B., B.S., 1951 (Univ. Adelaide), 283 Wakefield Street, Adelaide.

The undermentioned have been elected as members of the New South Wales Branch of the British Medical Association:

- Bearup, Dorothy Joy, M.B., B.S., 1950 (Univ. Sydney), Rachel Forster Hospital for Women and Children, Pitt Street, Redfern.
 Birbara, George, M.B., B.S., 1951 (Univ. Sydney), St. George Hospital, Kogarah.
 Bond, John Anthony, M.B., B.S., 1949 (Univ. Sydney), Royal Newcastle Hospital, Newcastle.
 Campbell, Charles Haxton, M.B., B.S., 1950 (Univ. Sydney), Sydney Hospital, Sydney.
 Castleden, Rosalind Archer, M.B., B.S., 1951 (Univ. Sydney), The Eastern Suburbs Hospital, Bondi Junction.
 Clowes, Gordon Joseph, M.B., B.S., 1951 (Univ. Sydney), Sydney Hospital, Sydney.
 Duncan, Glen Malcolm, M.B., B.S., 1951 (Univ. Sydney), 40 Princess Street, Mortdale.
 Englebrecht, Robert Cecil, M.B., B.S., 1951 (Univ. Sydney), Ryde District Soldiers' Memorial Hospital, Eastwood.
 Flenberg, Leonard Henry, M.B., B.S., 1951 (Univ. Sydney), Sydney Hospital, Sydney.
 Garrett, William John, M.B., B.S., 1951 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
 Geeves, Richard Banks, M.B., B.S., 1951 (Univ. Sydney), Royal Newcastle Hospital, Newcastle.
 Green, Leonard, M.B., B.S., 1947 (Univ. Sydney), 16 Rivers Street, Bellevue Hill.
 Jennings, John Colin, M.B., B.S., 1951 (Univ. Sydney), Sydney Hospital, Sydney.
 Kelly, William Heron, M.B., 1948 (Univ. Sydney), Ogilvie Street, Denman.
 Mitchell, Colin Ashton, M.B., B.S., 1950 (Univ. Sydney), Royal Hospital for Women, Paddington.
 O'Sullivan, Terence Joseph, M.B., B.S., 1948 (Univ. Sydney), 28 Tyler Crescent, Abbotsford.
 Perry, Grace Amelia, M.B., B.S., 1951 (Univ. Sydney), St. George Hospital, Kogarah.
 Phillips, John Bertram, M.B., B.S., 1946 (Univ. Sydney), 20 Thomas Avenue, Roseville.
 Ryan, Anthony Ian, M.B., B.S., 1951 (Univ. Sydney), Royal Prince Alfred Hospital, Camperdown.
 Stackpool, Frances Michael, M.B., B.S., 1951 (Univ. Sydney), 3 Malvern Avenue, Chatswood.
 Stephenson, John Hunter, M.B., B.S., 1951 (Univ. Sydney), Ryde District Soldiers' Memorial Hospital, Eastwood.
 Thomson, Roma Clare, M.B., B.S., 1950 (Univ. Sydney), 9 Wolseley Road, Mosman.
 Voss, John Henry Edward, M.B., B.S., 1951 (Univ. Sydney), Sydney Hospital, Sydney.
 Webster, Jessie Charlton, M.B., B.S., 1949 (Univ. Melbourne), 51 Milson Road, Cremorne.
 Wurth, William Geoffrey, M.B., B.S., 1951 (Univ. Sydney), 45 Olola Avenue, Vaucluse.
 Marel, Joseph Oscar, registered in accordance with the provisions of Section 17 (1) (c) of the *Medical Practitioners Act, 1938-1945*, 143 Forbes Street, Darlinghurst.

Sonnabend, Samuel Isaac, registered in accordance with the provisions of Section 17 (1) (c) of the *Medical Practitioners Act, 1938-1945*, 57 Hawkesbury Road, Westmead.

The undermentioned have been elected as members of the South Australian Branch of the British Medical Association:

- Black, Nancy Helen Barham, M.B., B.S., 1950 (Univ. Adelaide), 25 Northgate Street, Unley Park.
 Boten, Robert Gray, M.B., B.S., 1949 (Univ. Adelaide), 21 Elm Street, Unley Park.
 Cohen, Alexander Kevin, M.B., B.S., 1950 (Univ. Adelaide), 118 First Avenue, Mount Lawley, Western Australia.
 Drew, Michael John Roskilly, M.B., B.S., 1950 (Univ. Adelaide), 3 John Street, Hindmarsh.

Diary for the Month.

- APRIL 24.—New South Wales Branch, B.M.A.: Ethics Committee.
 APRIL 25.—Victorian Branch, B.M.A.: Council Meeting.
 APRIL 26.—New South Wales Branch, B.M.A.: Branch Meeting.
 APRIL 26.—South Australian Branch, B.M.A.: Branch Meeting, Listerian Oration.
 APRIL 27.—Queensland Branch, B.M.A.: Council Meeting.

Medical Appointments: Important Notice.

MEDICAL PRACTITIONERS are requested not to apply for any appointment mentioned below without having first communicated with the Honorary Secretary of the Branch concerned, or with the Medical Secretary of the British Medical Association, Tavistock Square, London, W.C.1.

New South Wales Branch (Medical Secretary, 135 Macquarie Street, Sydney)—All contract practice appointments in New South Wales.

Victorian Branch (Honorary Secretary, Medical Society Hall, East Melbourne): Associated Medical Services Limited; all Institutes or Medical Dispensaries; Australian Prudential Association, Proprietary, Limited; Federal Mutual Medical Benefit Society; Mutual National Provident Club; National Provident Association; Hospital or other appointments outside Victoria.

Queensland Branch (Honorary Secretary, B.M.A. House, 225 Wickham Terrace, Brisbane, B17): Brisbane Associated Friendly Societies' Medical Institute; Bundaberg Medical Institute. Members accepting LODGE appointments and those desiring to accept appointments to any COUNTRY HOSPITAL or position outside Australia are advised, in their own interests, to submit a copy of their Agreement to the Council before signing.

South Australian Branch (Honorary Secretary, 173 North Terrace, Adelaide): All Lodge appointments in South Australia; all Contract Practice appointments in South Australia.

Western Australian Branch (Honorary Secretary, 205 Saint George's Terrace, Perth): Norseman Hospital; all Contract Practice appointments in Western Australia. All government appointments with the exception of those of the Department of Public Health.

Editorial Notices.

MANUSCRIPTS forwarded to the office of this journal cannot under any circumstances be returned. Original articles forwarded for publication are understood to be offered to THE MEDICAL JOURNAL OF AUSTRALIA alone, unless the contrary be stated.

All communications should be addressed to the Editor, THE MEDICAL JOURNAL OF AUSTRALIA, The Printing House, Seamer Street, Glebe, New South Wales. (Telephones: MW 2651-2.)

Members and subscribers are requested to notify the Manager, THE MEDICAL JOURNAL OF AUSTRALIA, Seamer Street, Glebe, New South Wales, without delay, of any irregularity in the delivery of this journal. The management cannot accept any responsibility or recognize any claim arising out of non-receipt of journals unless such notification is received within one month.

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